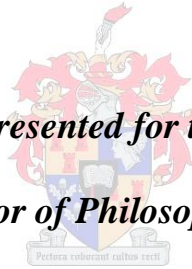


**HIV AND AIDS WITHIN THE PRIMARY HEALTH CARE
DELIVERY SYSTEM IN ZIMBABWE: A QUEST FOR A
SPIRITUAL AND PASTORAL APPROACH TO HEALING**

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SUPERVISOR: PROF. C. THESNAAR

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DECLARATION

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ABSTRACT

This qualitatively oriented Practical Theological research journey, informed by the philosophical ideas of postmodern, contextual, participatory and feminist theologies, postmodern and social construction epistemologies was based on a participatory action research through the therapeutic lens of narrative inquiry. The thesis is about the spiritual problems and spiritual needs of people living with HIV and AIDS and how they can be addressed as part of a holistic approach to their care within the primary healthcare delivery system in Zimbabwe. The research curiosity was prompted by the HIV and AIDS policy in Zimbabwe that advocates for a holistic approach to the care of HIV and AIDS patients within the primary health care delivery system. The recognition that healthcare has to be holistic for the best outcome for patients creates an expectation that spiritual care will also be incorporated into clinical practice. However there is a puzzling blind spot and a strange silence about the spiritual problems and spiritual needs of people living with HIV and AIDS within the HIV and AIDS policy. This has had the effects of reducing intervention programmes to purely medical, psychological and sociological. This research sought to correct such an approach by highlighting the role of spiritual care in the healing process of people living with HIV and AIDS as part of the holistic approach to their care.

The core information, on which this research is based, comes from the experiences of people living with HIV and AIDS who are receiving care within the primary health care delivery system in Zimbabwe. It sweeps away statistics and places those questing for spiritual healing at the core of the study. All the participants in the study affirmed that the why me questions as a summation of their indescribable and unimaginable spiritual pain felt in the spirit were directed to God. They confirmed that their spiritual problem was spiritual pain and their spiritual need therefore was spiritual healing from the spiritual pain of which God is believed to be the healer. The belief that God is the ultimate healer of the spiritual pain stood out from the midst of problem saturated narratives of spiritual pain and suffering as the unique outcome to reconstruct the alternative problem free stories of healing. The research opted for an approach that is informed by the experiences of people living with HIV and AIDS. In the light of the stories shared by the participants in this study, it became evident that there is an existing need within the Primary Health Care delivery system in Zimbabwe to provide spiritual care to people living with HIV and

AIDS. The research aimed at co-creating a spiritual care approach in which those living with HIV and AIDS as well as those working with them can be empowered to re-author the stories of patients' lives around their self preferred images.

The narrative approach was explored in this research as a possible therapeutic approach that could be used to journey pastorally with people living with HIV and AIDS in a non-controlling, non-blaming, non-directive and not knowing guiding manner that would permit the people living with HIV and AIDS to use their own spiritual resources in a way that can bring spiritual healing to their troubled spirits. The research also emphasizes the position of the people living with HIV and AIDS which they can inhabit and lay claim to the many possibilities of their own lives that lie beyond the expertise of the pastoral caregiver. The strong suggestion emerging from this study is that a spiritual care approach to healing must of necessity be integrated into the holistic approach to the care of people living with HIV and AIDS in Zimbabwe. The wish of participants that their spiritual well-being be considered in their health care adds momentum to this suggestion. Hence the research argues for the inclusion of a spiritual and pastoral approach to spiritual healing which links the patient's spirituality and pastoral care. The research does not claim to have the solutions or quick fix miracle to the complicated spiritual pain of people living with HIV and AIDS and neither claims to have the power to bring any neat conclusions to the spiritual healing of people living with HIV and AIDS. However, the research has the potential to stimulate a new story of spirituality as a vital resource in the healing process of people living with HIV and AIDS and ignoring it may defeat the purpose of a holistic approach to the care of people living with HIV. The re-authoring of alternative stories is an ongoing process but like in all journeys, there are landmarks that indicate achievements, places of transfer or starting new directions or turning around. Hence this research process may be regarded as a landmark that indicated a new direction in the participants' journey towards spiritual healing.

OPSOMMING

Hierdie kwalitatief-georiënteerde Praktiese Teologie navorsingsreis, geïnformeer deur die filosofiese idees van postmoderne, kontekstuele, deelnemende en feministiese teologie, postmoderne en sosiale konstruksie epistemologie, is gebaseer op deelnemende aksie-navorsing deur die terapeutiese lens van narratiewe ondersoek. Die tesis handel oor die spirituele probleme en navorsingsbehoefte van mense wat met MIV en vigs leef en hoe dit aangespreek kan word as deel van 'n holistiese benadering tot hul sorg binne die primêre gesondheidsorg-diensleweringstelsel in Zimbabwe. Die navorsing-belangstelling het ontwikkel na aanleiding van die MIV en vigs beleid in Zimbabwe wat 'n holistiese benadering tot die sorg van MIV en vigs pasiënte in die primêre gesondheidsorg-diensleweringstelsel bepleit. Die erkenning dat gesondheidsorg holisties moet wees om die beste uitkoms vir pasiënte te bied, skep 'n verwagting dat spirituele sorg ook by kliniese praktyk ingesluit sal word. Daar is egter in die HIV en vigs beleid 'n raaiselagtige blinde kol, 'n vreemde stilte oor die spirituele probleme en spirituele behoeftes van mense wat met MIV en vigs leef. Die gevolg is dat intervensie-programme gereduseer word tot slegs mediese, sielkundige en sosiologiese programme. Hierdie navorsing streef om dié benadering reg te stel deur die beklemtoning van die rol van spirituele sorg in die heling-proses van mense wat met MIV en vigs leef as deel van die holistiese benadering tot hul sorg.

Die kerninligting waarop hierdie navorsing gegrond is, vloei voort uit die ervarings van mense wat leef met MIV en vigs en sorg ontvang binne die primêre gesondheidsorg-diensleweringstelsel in Zimbabwe. Dit vee statistiek van die tafel af en plaas diegene wat soek na spirituele heling, in die hart van die ondersoek. Al die deelnemers aan die ondersoek het bevestig dat hul “Waarom ek?” vrae, as opsomming van hul onbeskryflike, ondenkbare geestelike pyn, aan God gerig is. Hulle het bevestig dat hul spirituele probleem spirituele pyn is, en dat hul spirituele behoefte dus spirituele genesing is van die spirituele pyn, die pyn waarvan geglo word dat God die geneser is. Die geloof dat God die opperste geneser is, het uitgestaan te midde van die probleem-deurdrenkte narratiewe van spirituele pyn en lyding as die unieke uitkoms om alternatiewe probleem-vrye verhale van heling te herkonstrueer.

Die navorsing het 'n benadering gekies wat geïnformeer is deur die ervarings van mense wat leef met MIV en vigs. In die lig van die verhale wat die deelnemers aan die studie gedeel het, het dit duidelik geword dat daar 'n behoefte is dat spirituele sorg ook aan mense wat leef met MIV en vigs verskaf word in die primêre gesondheidsorg-diensleweringstelsel in Zimbabwe. Die doel van die navorsing was om saam 'n spirituele sorg benadering te skep waarin diegene wat met MIV en vigs leef, sowel as diegene wat met hulle werk, bemagtig kan word om die stories van pasiënte se lewens te herskryf in terme van pasiënte se verkose beelde.

Die narratiewe benadering is in hierdie studie ondersoek as 'n moontlike terapeutiese benadering wat gebruik kan word om pastoraal te reis met mense wat leef met MIV en vigs op 'n manier wat nie kontroleer, beskuldig, voorskryf of weet nie, maar wat mense wat met MIV en vigs leef eerder begelei en toelaat om hul eie spirituele bronne te gebruik op 'n manier wat spirituele genesing vir hul gekwelde siele kan bring. Die navorsing beklemtoon ook die posisie van mense wat leef met MIV en vigs waarin hulle spirituele moontlikhede, areas van hul lewens kan eien en bewoon, moontlikhede wat buite die bereik van pastorale versorgers lê.

Uit hierdie studie vloei 'n sterk suggestie dat 'n spirituele benadering tot genesing noodwendig geïntegreer moet wees in die holistiese benadering tot die sorg van mense wat leef met MIV en vigs in Zimbabwe. Deelnemers se wens dat hul spirituele behoeftes ook in hul gesondheidsorg oorweeg word, gee aan dié suggestie verdere momentum. Derhalwe argumenteer hierdie navorsing ten gunste van die insluiting van 'n spirituele en pastorale benadering tot spirituele genesing wat die pasiënt se spiritualiteit en pastorale sorg verbind.

Die studie maak nie daarop aanspraak dat dit antwoorde of 'n wonderbare kits-oplossing bied vir die gekompliseerde spirituele pyn van mense wat leef met MIV en vigs nie, of spirituele genesing netjies afsluit nie. Die navorsing het egter wel die potensiaal om 'n nuwe verhaal te stimuleer van spiritualiteit as 'n deurslaggewende bron in die genesingsproses van mense wat leef met MIV en vigs. Om spiritualiteit te ignoreer, mag dalk die doel verydel van 'n holistiese benadering tot die sorg van mense wat met MIV en vigs leef. Die herskryf van alternatiewe verhale is 'n voortdurende proses, maar soos alle reis, is daar landmerke wat prestasies aandui, en ook punte van verplasing, rigtingverandering of selfs ommekeer. Hierdie navorsing kan beskou word as 'n landmerk van 'n verandering van rigting in deelnemers se reis na spirituele genesing.

DEDICATION

This dissertation is dedicated to the seven participants who journeyed with me on this research journey as co-researchers, co-authors, co-creators and as experts of their own lives. Thank you for changing my life. I will always remember you as **Mukoma Tippy, Mukoma T.J, Mukoma K. K, Mother, Mai Chipu, Mai Paida and Mainini Shupi**. Keep up the courage and it shall be well.

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CONTENTS

PRELIMINARIES

Declaration	i
Abstract: English	ii
Opsomming	iv
Dedication	vi
Acknowledgements	vii
Contents	ix
Acronyms	xvi
List of figures and graphs	xviii

CHAPTER ONE: BACKGROUND TO THE STUDY

CHAPTER ONE: BACKGROUND TO THE STUDY	1
1.0 Introduction	1
1.1 Background	1
1.2 The spiritual and pastoral approach to healing	7
1.3 Motivation	12
1.4 Problem Statement	15
1.5 Research Question	17
1.6 Aim of the research	18
1.7 Research goals	19
1.8 Future use of the research	19
1.9 Contribution to Practical Theology	20
1.9.1 Pastoral Care as a sub-division of Practical Theology	20
1.9.1.1 Pastoral counseling	22
1.9.1.1.1 Clinical pastoral care	23
1.10 The theological framework of the research	24
1.10.1 Contextual approach to Practical Theology	24
1.10.1.1 Knowing is Contextual	26
1.10.1.2 Voicing Change	27
1.10.1.3 Doing Theology	27
1.10.2 Participatory approach to Practical Theology	28
1.10.2.1 Knowing is local	28
1.10.3 Postmodern theology	29
1.10.4 Feminist Theology	31
1.11 Theoretical Framework of the research	33
1.11.1 Postmodern epistemology	33
1.11.2 Social construction	34

1.12 The research methodology	37
1.12.1 Qualitative research methodology	38
1.12.1.1 Participatory action research	40
1.12.1.1.1 Cross pollinating narrative research and participating action research	43
1.12.1.2 Narrative Approach: A turn in research	44
1.12.1.2.1 A narrative epistemology	45
1.12.1.2.2 Narrative theory	46
1.12.1.2.3 Narrative research	47
1.12.1.3 Narrative therapy: An overview	50
1.12.1.3.1 Basic philosophy of narrative therapy	51
1.12.1.3.2 Theory of the person and development in narrative therapy	53
1.12.1.3.3 Overview of the therapeutic atmosphere	53
1.12.1.3.4 The position of the researcher	54
1.12.1.3.5 Roles of the participants	55
1.12.1.3.6 Assessment	57
1.12.1.3.7 Language	57
1.12.1.3.8 Goals of narrative therapy	58
1.12.1.3.9 Data collection and data analysis	59
1.12.1.3.10 Central Constructs in narrative therapy	61
1.12.1.3.10.1 Problem saturated stories	62
1.12.1.3.10.2 Unique outcomes	64
1.12.1.3.10.3 Re-authoring conversations: The alternative stories	65
1.12.1.3.11 Narrative practices used	66
1.12.1.3.11.1 Naming the problem: A problem is a problem	66
1.12.1.3.11.2 Exploring the effects of the problem: Deconstruction	67
1.12.1.3.11.3 Thickening the alternative stories: Witnessing and expanding	68
1.12.1.3.11.4 Externalizing conversations	70
1.12.1.3.11.5 Questioning: The basic tool of narrative therapy	71
1.12.1.3.11.6 Responsive-active listening	72
1.12.1.3.11.7 Not knowing position	73
1.12.1.3.11.8 The journey metaphor	74
1.12.1.3.11.9 Reflexivity as reflection	75
1.12.1.3.11.9.1 Reflecting teams	75
1.13. Pilot study	76
1.14 Research site	77
1.15 Research Participants	78
1.15.1 The sample for the study	78
1.16 Ethical considerations	79
1.17 Thesis Outline	82
1.18 Conclusion	86

CHAPTER TWO: THE HIV AND AIDS EPIDEMIOLOGY, EVOLUTION AND RESPONSE

1.0 Introduction	87
2.1 Geographical and historical context of Zimbabwe: An overview	87

2.2 HIV and AIDS in Zimbabwe: An overview	90
2.3 The social determinants of HIV	93
2.3.1 Gendered Dimension	93
2.3.2 Customary Law	96
2.3.2.1 Marriages	97
2.3.2.2 Motherhood	98
2.3.2.3 Lobola/Bride prize	99
2.4 The economic determinants of HIV	100
2.4.1 The land question	101
2.4.2 The Economic Structural Adjustment Programme (ESAP)	102
2.5 The political determinants of HIV and AIDS in Zimbabwe	105
2.5.1 The colonial past	106
2.6 The HIV Prevalence in Zimbabwe	109
2.6.1 Sources of data for the estimate of HIV prevalence in Zimbabwe	110
2.6.2 National and International responses to the HIV prevalence decline in Zimbabwe	110
2.6.3 Who takes the credit for the decline of the HIV prevalence in Zimbabwe?	111
2.7 National response to the HIV and AIDS pandemic	114
2.7.1 Initial Response	115
2.7.2 The Zimbabwe National AIDS Council (NAC)	115
2.7.3 The Multi-sectoral approach in Zimbabwe	116
2.7.3.1 The battle cry	118
2.7.4 Zimbabwe National HIV and AIDS Policy (ZNHAP)	119
2.8 The primary health care delivery system in Zimbabwe (PHC)	120
2.8.1 Post Independence (1980-1990) and the PHC	121
2.8.2 Liberalization and provision (1990-2000)	122
2.8.3 The economic downturn (2000 to date) and the PHC	123
2.9. PHC system in Zimbabwe	124
2.9.1 The referral process within the PHC	125
2.9.2 Health Care Workers within the PHC	126
2.9.3 PHC and Zimbabwe Traditional Healers	127
2.9.4 The integration of HIV and AIDS into the PHC in Zimbabwe	127
2.9.4.1 The benefits of the integration of HIV and AIDS into the PHC	128
2.9.4.2 The limitations of the integration	129
2.10 PHC and VCT	130
2.10.1 HIV Testing	130
2.10.2 Voluntary counseling and testing (VCT)	131
2.11 Elements of VCT	133
2.11.1 Pre-test counselling	133
2.11.2 Post-test counselling	133
2.11.3 Counselling, care and supportive after VCT	134
2.11.4 Reflection on HIV counseling within the PHC in Zimbabwe	134
2.12 The Missing gap within the holistic approach to care	136
2.13 Conclusion	138

CHAPTER THREE: STORYING THE UNSTORIED: PROBLEM SATURATED STORIES	141
3.0 Introduction	141
3.1 Storying the unstoried	142
3.2.1 Mai Chipu tells her story	144
3.2.1.1 The participating team's reflections on Mai Chipu's story	146
3.2.2 Amai Paida tells her story	148
3.2.2.1 The participating team's reflections on Mai Paida's story	150
3.2.3 Mukoma K.K tells his story	152
3.2.3.1 The participating team's reflections on Mukoma K.K's story	154
3.2.4. Mainini Shupi tells her story	157
3.2.4.1 The participating team's reflections on Mainini Shupi's story	158
3.2.5 Mukoma T.J tells his story	159
3.2.5.1 The participating team's reflections on Mukoma T.J's story	161
3.2.6 Mukoma Tippy tells his story	163
3.2.6.1 The participating team's reflections on Mukoma Tippy's story	165
3.2.7 Mother tells her story	168
3.2.7.1 The participating team's reflections on Mother's story	171
3.3 Reflecting on creating a caring community with the participants	172
3.4 Personal reflections	175
3.4.1The problem saturated stories.	175
3.4.2 HIV and AIDS education	177
3.4.3 HIV Testing	177
3.4.4 Shona marriages in the context of HIV and AIDS	178
3.4.4.1. Marriage and the gendered HIV transmission	179
3.4.4.1.2 Male supremacy and male sexuality	179
3.4.4.1.2 Shona women and the feminization of the HIV epidemic	180
3.4.4.1.3 Late marriage	181
3.4.4.1.4 Lobola in Shona marriages in the context of HIV and AIDS	181
3.4.4.1.5 Child bearing in Shona marriages and HIV	182
3.4. 5 Infidelity and the Sexual Offences Act in Zimbabwe	183
3.4.5.1 The virtue of faithfulness	184
3.4. 6 Divorce within the HIV pandemic	184
3.4.7 Discordant Couples	185
3.4.8 Condom use and attitudes towards condoms in marriage	187
3.4.9 HIV status disclosure	188
3.4.9.1 HIV disclosure within the family, community and society	188
3.4. 9.2 HIV disclosure within the church	190
3.4.10 The power of Language	192
3.5 Conclusion	193
 CHAPTER FOUR: WEAVING THEMES TOGETHER: CONSTRUCTING NEW KNOWLEDGE	 195
4.0 Introduction	195
4.1 The success story of Anti-Retroviral Therapy (ART)	196
4.1.1 ART for life: The challenges	199

4.2 The new life: A heavy burden	202
4.2.1 Spiritual root cause of HIV and AIDS	202
4.2.1.1 God and the ancestors	204
4.2.1.2 The Witchcraft and Spirit theories	209
4.2.1.3 Sin and punishment	212
4.2.1.4 The chain reaction: Broken relationships and HIV infection	214
4.3 The social construction of illness and healing among the Shona people	217
4.3.1 Consulting with traditional healers	217
4.3.2 Consulting with the faith healers or prophets	220
4.3.3 The biomedical intervention	223
4.3.4 The interplay	225
4.3.5 The quest for healing: The instinctive eclecticism	228
4.4 Spiritual Pain	231
4.4.1 Mai Paida and the inner pain	231
4.4.2 Mai Chipa and the spiritual pain	233
4.4.3 A letter to and from Mainini Shupi: A troubled spirit	235
4.4.4 Mukoma Tippy and the struggle inside	237
4.4.5 Spiritual pain and the human spirit	237
4.4.6 Manifestations of spiritual pain	240
4.4.6.1 Anger as a symptom of spiritual pain	240
4.4.6.2 Doubt and meaninglessness as symptoms of spiritual pain	241
4.4.6.3 Isolation and abandonment as symptoms of spiritual pain	242
4.4.6.4 Hopelessness and meaninglessness as symptoms of spiritual pain	242
4.4.6.5 Confusion about God's love as a symptom of spiritual pain	243
4.4.6.6 Internalized homophobia as a symptom of spiritual pain	243
4.4.6.7 Guilt and guilt feelings as symptoms of spiritual pain	244
4.5 Spiritual needs of people living with HIV and AIDS	245
4.5.1 Linking God to the spiritual needs of the participants: The unique outcome	247
4.6 Conclusion	248

CHAPTER FIVE: THE QUEST FOR SPIRITUAL HEALING: SPIRITUALITY AS A HIDDEN TREASURE	250
5.0 Introduction	250
5.1 Re-authoring the alternative stories	251
5.2 The unique outcome: Only God can heal	253
5.2.1 The Shona-Biblical understanding of God	255
5.3 Spirituality within the HIV discourse in the postmodern paradigm: a hidden treasure	257
5.3.1 Spirituality: Rediscovering a hidden resource	258
5.3.1.1 Definition of spirituality	261
5.4 Re-authoring conversation map	262
5.5 Thickening the alternative stories: Witnessing and expanding conversations	267
5.5.1 Re-membering conversations	268
5.5.2 Outside witness	271
5.5.3 Expanding the conversations: Rituals and celebrations	276
5.5.3.1 Rituals and celebrations	277

5.6 Reflecting on the emerging spiritual care	281
5.7 Conclusion	283
CHAPTER SIX: REFLECTIONS ON THE RESEARCH JOURNEY	285
6.0 Introduction	285
6.1 Reflecting on the therapeutic space	286
6.2 Reflecting on the theological and theoretical framework of the research	288
6.2.1 Reflecting on contextual theology to practical theology	289
6.2.2 Reflecting on feminist theology	290
6.2.3 Reflecting on Postmodern Theology	291
6.2.4 Reflecting on Social construction	293
6.2.5 Reflecting on participatory action research	294
6.2.5.1 Reflecting on the narrative approach to research	295
6.3 Reflecting on power sharing	298
6.4 Reflecting on the human text and written text	299
6.5 Reflecting on the re-authoring of alternative stories	300
6.6 Reflecting on the journey metaphor	304
6.7 Reflecting on spirituality and spiritual care	305
6.7.1 Reflecting on conversations with God	306
6.8 My personal reflections	308
6.8.1 Reflecting on my position	310
6.8.2 Reflecting on my use of narrative therapy	312
6.8.3 Reflecting on how I confronted my own fears	313
6.8.4 Reflecting on ethical considerations	313
6.8.5 Reflecting on how psychosocial issues were dealt with	314
6.8.6 Reflecting on co-authoring	315
6.9 Conclusion	315
CHAPTER SEVEN: CONCLUSIONS AND RECOMMENDATIONS	317
7.0 Introduction	317
7.1 Research question revisited	317
7.2 Research aim revisited.	318
7.3 Research goals revisited	319
7.4 Conclusions	324
7.4.1 Chapter One	324
7.4.2 Chapter Two	325
7.4.3 Chapter Three	327
7.4.4 Chapter Four	328
7.4.5 Chapter Five	329
7.4.6 Chapter Six	330
7.5 Limitations of the study	331
7.6 Research Findings	333
7.7 Recommendations	336
7.7.1 Recommendations from research participants	337
7.7.2 Recommendations for Practical Theology and pastoral theology	339

7.7.2.1 Pastoral care	341
7.7.2.1.1 Narrative approach with people living with HIV and AIDS	343
7.7.4 Recommendations for the PHC	345
7.7.5 Recommendations for future research	349
7.8 Conclusion: Collecting my thoughts	351
 BIBLIOGRAPHY	 353
 APPENDICES	 403

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ART	Anti Retroviral Therapy
DFID	Department of Foreign Development
ESAP	Economic Structural Adjustment Programme
GOZ	Government of Zimbabwe
HARP	Humanitarian Assistance and Recovery Programme
HIV	Human Immune Virus
IMF	International Monetary Fund
MDG	Millennium Development Goals
MOHCW	Ministry of Health and Child Welfare
NAC	National AIDS Council
NGO	Non-Governmental Organizations
PAR	Participatory Action Research
PLWHA	People living with HIV and AIDS
PHC	Primary Health Care
PSC	Public Service Commission
PVO	Private Voluntary Organization
SADC	Southern African Development Community
TASO	The AIDS Service Organization
UNCEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

UNDCP	United Nations International Drug Control Programme
UNESCO	United Nations Educational Scientific and Cultural organization
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZDHS	Zimbabwe Demographic and Health Survey
ZIMPREST	Zimbabwe Programme for Economic and Social Transformation
ZINATHA	Zimbabwe National Association of traditional healers
ZNAP	Zimbabwe National AIDS Policy

LIST OF FIGURES AND GRAPHS

Figures

Figure 1

Map of Zimbabwe 88

Figure 2:

The British colonialism and the HIV epidemic in Southern Africa 106

Figure 3:

The progression of the PHC referral system in Zimbabwe 124

Figure 4:

Voluntary counselling and testing as an entry point for HIV prevention and care 132

Graphs

Graph 1: The prevalence of HIV in Zimbabwe. 110

CHAPTER ONE

BACKGROUND TO THE RESEARCH JOURNEY

1.0 Introduction

Chapter one provides an introduction and overview of this qualitatively oriented Practical Theological research journey. The chapter consists of the background to the research journey, the motivation for carrying out the research, the statement of the problem, the research question, the aim and goals of the study, the theological and theoretical frameworks for the research, the research methodology, the research site, research participants, data collection and analysis and ethical considerations. Finally, the chapter provides an outline of the thesis chapters. The thesis is about the spiritual problems and spiritual needs of people living with HIV and AIDS and how they can be addressed within the primary health care delivery system in Zimbabwe as part of a holistic approach to their care. Specifically, the research argues for the inclusion of a spiritual care approach to healing into the primary health care delivery system in Zimbabwe as part of the holistic approach to the care of people living with HIV and AIDS. The nature of the research question and the aim of the research demanded that an empirical dimension of the research be done with people living with HIV and AIDS who are receiving care at the Gweru Provincial Hospital in Zimbabwe as research participants. The participants became the primary sources of data presented in this thesis because they were regarded as the experts of their lives.

1.1 Background

Zimbabwe is one of the worst countries affected by the HIV and AIDS pandemic in the entire world and the consequence has been widespread death and massive suffering among the people. The UNAIDS (2008:1) report, affirms that Zimbabwe is at the epicentre of the epidemic, experiencing one of the hardest AIDS pandemics in the world and has reached catastrophic proportions with around one in seven adults living with HIV. The HIV and AIDS scourge is causing unbearable suffering on persons, families and communities affected by the pandemic in Zimbabwe¹. On the other hand, Zimbabwe has to confront a number of severe crises in the past few years including, an unprecedented rise in inflation, a severe cholera outbreak, and high rates of unemployment, a tense political climate and a near total collapse of the health system. Hence,

¹ Rodlach (2006:1)

responding effectively to the pandemic has been difficult and the suffering on the people continues to amount to unimaginable heights of pain affecting all segments of society but hitting hard on women and children².

The first reported case of AIDS in Zimbabwe occurred in 1985 and by the end of 1980s around 10% of the adult population was thought to be infected with HIV and this figure rose by 1997, peaking and stabilizing at 29% between 1995 and 1997³. The Zimbabwe Ministry of Health and Child Welfare (MOHCW) (2010:1) report, that Zimbabwe has a projected population of 12, 7 million people and it is approximated that 1.8 people in Zimbabwe live with HIV and AIDS and about 90% of the infected are not aware of their status. It is approximated that about 600 000 of those carrying the virus have the signs and symptoms of AIDS and require various degrees of care and support. It is also estimated that 597 293 adults and children were in urgent need of anti retroviral therapy (ART). The same report approximates that an average of 2 500 people die as a result of HIV and AIDS per week and life expectancy has fallen from 60 years in 1990 to 43 years due to HIV and AIDS. On the other hand since this point, the HIV prevalence is reported to have declined, making Zimbabwe one of the first African countries to witness such a trend. According to the National AIDS Council (NAC) (2011) in the Zimbabwe National Strategic Plan II 2011-2015 report, indicates that according to the government figures the adult prevalence was 24.6% in 2003 and fell to 20.1% in 2005, 15.3% in 2007 and 14.26% in 2009

Earlier on, Parirenyatwa in the Ministry of Health and Child Welfare (MOHCW) (2004: iii) report admits that the HIV and AIDS epidemic is the most serious challenge faced by Zimbabweans since independence. Parirenyatwa in MOHCW (2004:1) continues to highlight that, life expectancy at birth has fallen below levels that existed at independence, wiping out the gains of a generation and the consequences of the AIDS pandemic are going to be around for decades. HIV and AIDS has made its in road into all towns, cities and even to the remotest parts of the country inflicting not only physical pain as a disease, but emotional, psychological and existential crisis raising questions which are far from being purely medical or clinical. Therefore, the hunger and thirst for care among all segments of the population in Zimbabwe can never be overstated considering that there is no cure for the deadly scourge.

² Avert (2008:1) report

³ Avert (2009:1) report

In 1980 Zimbabwe became independent raising the Zimbabwean flag officially for the first time. The decades of the 1980 to 1990 witnessed the nation wrestle with varying degrees of success to find just solutions to political, social and economic issues and a strong sense of optimism helped steer the country through these issues⁴. Terry (2000: xvii) adds, “yet, the most fundamentally difficult question facing the nation is one that nobody ever imagined, that is how to deal with the AIDS pandemic devastating the nation.” In line with this, Rodlach (2006:39) asserts that although the first case of HIV was detected in 1985 in Zimbabwe, it was only declared a national disaster in 2002 by President Robert Mugabe. As such, the Government of Zimbabwe (GOZ) started responding to the impact of HIV and AIDS in 1987 through the Ministry of Health and Child Welfare. In this regard, President Robert Mugabe called for a multi-sectoral and multi-disciplinary response to mitigate the impact of HIV and AIDS on the people⁵. Hence, the GOZ through the Ministry of Health and Child Welfare established the National AIDS Council (NAC) to coordinate the national HIV and AIDS programme.

In 1999, the NAC finalized two important policy documents to guide the national response to the pandemic with the support from USAID which are, “*The National Policy on HIV and AIDS for Zimbabwe and the Strategic Framework for a National Response to HIV and AIDS*”⁶. The National Policy on HIV and AIDS for Zimbabwe is a comprehensive document that addresses all critical issues in the fight against AIDS. It has been widely disseminated through Zimbabwe and most of those working in the field are familiar with it. The National policy on HIV/AIDS was developed in order to promote and guide present and future responses to AIDS in Zimbabwe. In the National Policy on HIV and AIDS for Zimbabwe (1999) Guiding Principle Two, stipulates that because of the stigma still attached to HIV and AIDS, the rights to people living with HIV and AIDS (PLWHA) need special consideration hence providing care and counselling is essential in order to minimize the personal and social impact of HIV and AIDS. In Zimbabwe, the care of people living with HIV and AIDS is integrated into the primary health care delivery

⁴ Terry (2000:xvii),

⁵ Jackson (2005:370)

⁶ USAID/Zimbabwe HIV and AIDS Strategic framework for a national response (2003:11),

system (PHC). Hence, in the Zimbabwe National Policy on HIV and AIDS (1999)⁷ Article 5 entitled, Care for People Living with HIV and AIDS states;

The needs of individuals with HIV and AIDS, their families and communities pose a serious challenge to the health care delivery and social welfare system. A holistic approach to care should address the physical, psychological and social needs of people with HIV and AIDS and their families. People affected by HIV and AIDS should be treated with respect and dignity; Health professionals and others providing care should be sensitive to the diverse needs of PLHWA and their families.

Furthermore, the National Policy on HIV and AIDS for Zimbabwe (1999) Article 5:3 states;

Counselling is acknowledged as a vital component of HIV and AIDS prevention and care. HIV counselling is stipulated as having two main functions that are often interrelated. Firstly, it is to offer psychological and social support to enable those infected and affected by HIV to deal with a wide range of emotional, social, economic and medical problems. The diagnosis of HIV infection or the realization that one has been exposed to HIV infection has emotional, social and medical consequences.

The second function of counselling is to enable the concerned persons prevent HIV infection by assessing and understanding risky life styles and define their potential for behavior change.

In other words, the above policy articles indicate that, a holistic approach to the care of people living with HIV and AIDS should include their, physical, psychological and social needs. I observed that the policy is silent about the spiritual needs of people living with HIV and AIDS. Although the above policy article, acknowledges HIV counseling as a vital component of HIV and AIDS prevention and care, it mentions the need for psychological and social support for people living with HIV and AIDS to help them deal with a wide range of emotional, social,

⁷ The research takes into account the 1999 National HIV and AIDS policy of the Republic of Zimbabwe and should be interpreted in conjunction with the USAID/Zimbabwe HIV and AIDS Strategic framework for national response (2003); the Zimbabwe National Guidelines on HIV testing and counselling (2005); the Zimbabwe National Strategic Plan 2011-2015 and the HIV and AIDS research priorities for Zimbabwe 2010-2012.

economic and medical problems. Once again the policy is silent about the spiritual problems of people living with HIV and AIDS. The silence on the spirituals needs and spiritual problems of people living with HIV and AIDS puzzled me. When I observed this puzzling blind spot on the spiritual needs and problems of people living with HIV and AIDS in the HIV and AIDS policy of Zimbabwe, I became curious to find out from people living with HIV and AIDS whether they had spiritual needs and spiritual problems and if they did, how the spiritual needs and spiritual problems could be addressed within the primary health care delivery system along with their physical, psychological and social needs. To me excluding the spiritual needs and spiritual problems of people living with HIV and AIDS from the above policy is a huge gap which calls for research considering that eighty percent of the Zimbabwean people believe in God or higher power⁸.

In Zimbabwe, disease or sickness remains a spiritual problem and this means that spirituality continues to play a significant role for patients in their quest for healing. Kazembe (2009: 55) writes that the spiritual worldview of the Zimbabwean people plays an important role in guiding people when they are sick and healing constitutes a major concern for the Zimbabwean patient. In addition, the Zimbabwe people's spirituality has a strong foothold in contemporary Zimbabwe and it is seen as an intergral part of their everyday lives as evidenced in their culture, literature, politics and health⁹. Richards (2000:143) asserts that in Zimbabwe, spirituality is inseparate from health and healing and this relationship applies to both the traditional and Christian spirituality. Dahlin (2001:113) states that, the three medical systems in Zimbabwe which are traditional medicine, primary health care and faith healing appear exclusive but patients are constantly moving back and forth between treatment options in search for healing but to no avail. If this be the case, my assertion was that, to continue ignoring the spiritual needs and problems of people living with HIV and AIDS in Zimbabwe could be disastrous to a holistic approach to their care. Hence, I wanted to find out from the people living with HIV and AIDS what their spiritual problems and needs were and how they could be addressed within the primary health care delivery system in Zimbabwe. Therefore, the research journey was done with seven people living with HIV and AIDS who are receiving care at the Gweru Provincial Hospital in Zimbabwe.

⁸ Chitando (2002:40)

⁹ Kazembe (2009:55)

In this research journey, I wanted to listen to the stories of people living with HIV and AIDS in order to gain an understanding of their spiritual problems and needs as in-context experience. I was not only interested in their descriptions of experiences but also and foremost their own interpretations of the pandemic as well as their care and counselling needs in this regard. The aim was not to describe a general context, but to present a specific concrete and local context which also pointed beyond the local context. This contributed towards co-creating spiritual care that is contextual and relevant to people living with HIV and AIDS as co-researchers and co-creators (1.12.1.1). The participants' spirituality (5.3) became a valuable resource in the therapeutic conversations in the process towards spiritual healing.

On the other hand, throughout the research journey, I wanted to establish that people living with HIV and AIDS have spiritual needs and problems which should be addressed within a holistic approach to their care within the primary health care delivery system. Therefore, I wanted to study and understand the spiritual issues and concerns of people living with HIV and AIDS which are being overlooked within the primary health care delivery system in Zimbabwe. I wanted to learn from the people living with HIV and AIDS what could be the spiritual root causes of HIV and AIDS from their perspectives and how they contributed to their quest for healing. In caring for the whole person, it seemed paramount to me to take the spiritual dimension of being human into consideration. Frankl (1969:9) affirms that it is the spiritual dimension that makes us humans. In this same line of thought, Sperry (2001: 24) affirms that, the spiritual dimension of being human is fundamental to all other dimensions of human experiences, namely somatic, social, psychological and moral. Sperry further asserts that the spiritual dimension may or may not involve any formal affiliation with a religious tradition but it reflects the beliefs, effects and behaviours associated with the basic spiritual need for self-transcendence. The uniqueness of the spiritual care approach to healing that this research proposes acknowledges the spirituality of people as playing a vital role in their healing process. Hence their spiritual well being will "buffer existential crisis and counter their adverse influence" and it will sustain "hope, purpose and self agency" and "play a role in countering illness" (Griffith and Griffith 2002:267).

My conviction is that, a strong functioning public health care delivery system is critical to addressing a generated epidemic such as that found in Zimbabwe. I acknowledge that Non Governmental Organizations, Faith Based Organizations and private sector-operated programs are effectively leading in certain target populations in the care and counselling of people living with HIV and AIDS. However, my argument is that they do not have national coverage. My assumption therefore is that supporting the public health care delivery system, with its widespread infrastructure, is the most effective means of reacting to the care and counselling needs of people living with HIV and AIDS rather than creating a parallel system.

Therefore, the research intended to demonstrate the advantages to the health profession itself, to the policy makers as well as to the public, of an integrated approach to the care of people living with HIV and AIDS which includes their spiritual care as part of the holistic care approach. To highlight the inadequacies of the primary health delivery system in caring and supporting people living with HIV and AIDS Magezi (2007:33) asserts that although people acknowledge the biomedical model of causes and treatment of HIV and AIDS, people still seek help from the traditional healers in Zimbabwe and this is not a rejection of scientific medicine but an acknowledgement of its limitations and to highlight its impoverishment¹⁰. This research argues for the inclusion of a spiritual care approach to healing into the primary health care delivery system which acknowledges people living with HIV and AIDS as experts of their lives.

1.2 The spiritual and pastoral approach to healing

The research participants (1.12.1.1) during the research journey expressed that they experienced spiritual pain in their spirits and they need spiritual healing. The participants also wished that their spiritual well-being be considered in their health care as part of a holistic approach to their care. In this regard, a spiritual care approach to meet the spiritual needs of the participants would be one which links “spirituality” and “pastoral care”. Hence, in the spiritual care approach which emerged from this research journey, the concepts “spirituality” and “pastoral care” are linked in the process of addressing the spiritual needs of patients in a creative and dynamic tension where their complex interrelatedness and interconnectedness interacted in the process of doing spiritual

¹⁰Aldridge (2000:70)

care with people living with HIV and AIDS. This spiritual care approach is therefore coined, a “spiritual and pastoral approach to healing.” In other words, this approach acknowledges the spiritual dimension of the patient as experiencing pain and suffering from living with HIV and AIDS which raises the need for spiritual healing. Frankl (1969:10) stresses the importance of appealing to human’s spirituality as follows,

A therapist, (pastoral caregiver) who ignores man’s spiritual side and is thus forced to ignore the will to meaning, is giving away one of the most valuable assets. Again and again we have seen that an appeal to continue life, to survive the most unfavorable conditions can be made only when such survival appears to have meaning. That meaning must be specific and personal, a meaning which can be realized by this one person alone. For we must never forget that every man is unique in the universe. (Emphasis is mine)

In brief, Truter and Kotze (2005:974) describe spirituality (5.3.1.1) as the way in which people experience God’s presence. Hence it is experiential, personal and subjective. According to Heintink (1993:35) pastoral care is, “searching with people for a way in which to experience their situation in the presence of God.” According to Heitink (2000:131-135), healing is a function of pastoral care. In this regard, Nouwen (1977:24-25) states that “healing means revealing that our human wounds are most intimately connected with God.” Hence, healing does not mean taking away the spiritual pain and suffering, but rather connecting the patient’s pain with the greater human experience of pain. As indicated by Nouwen (1977:26) the challenge is to see suffering and pain as part of and not separate from God’s work in this world. Therefore, the pastoral caregiver does not need psychological techniques to accomplish healing. The patient on the other hand does not actualize authenticity by means of psychological competency but by a profound spirituality. The challenge from the perspective of spirituality is to discover God at work in the midst of all the spiritual pain and suffering and what He is up to in that particular situation. Therefore, in this research journey, spiritual care meant discovering with the participants their spiritual resources that would sustain them while living with HIV and AIDS. Spiritual care facilitated the beginning of spiritual healing, spiritual growth, resilience and transformation. Spiritual care empowered the participants to transcend the problems of their present situation and supplied the hope for spiritual healing against the odds of a seemingly

hopeless situation of living with HIV and AIDS. The spiritual care which emerged from this research journey was co-created by the participants with me as the pastoral caregiver and the participants' spirituality emerged as a vital resource in the journey towards spiritual healing.

On the other hand, the spiritual and pastoral approach to healing acknowledges more specifically the "ultimate focus which is God" (De-Jongh van Arkel 2000:210) as an inherent distinguishing character of pastoral care. In this regard, De Jongh van Arkel (2000:211) adds that there is a difference between pastoral work and psychotherapy in the observation that psychotherapy usually leaves the relationship with God aside. It is this difference between pastoral care and other health care professionals that this research focused on in the co-creation of spiritual care with the participants where the participants are viewed as the experts of their own lives. In this regard, spiritual care acknowledges the spiritual dimension of the human person and subsequently engages with each person's fundamental search for meaning, value and purpose in life¹¹. The spiritual and pastoral approach to healing advocates for a direction in pastoral care with people living with HIV and AIDS that promotes not only a change in action but also a change in attitude at a spiritual level (Isherwood and McEwan 1993:11). The patient's spirituality is understood as the meaning he or she gives to or finds with God in the experienced life context of her or his illness. This can only happen when the pastoral conversations become conversations with God. In this way we can approach pastoral care as a means of respecting the patient's unique descriptions and experiences of his or her own illness in relation to God.

In addition, Pattison (1993:204) adds that the focus of pastoral care is "gradually turning from the focus on crisis and pathology which is a turn away from individualized problem centredness to corporate growth in community." The spiritual and pastoral approach helps people whose lives are connected to come to richer descriptions of their situations. The approach does not focus on pathology but on the patient's unique context and on caring with the patient. Sevenhuijsen (1998:15) elaborates on this by stating that the "ethics of care" is based on a dual commitment. The approach further assumes that people recognize and treat others as different and take into account other people's individual views of the world. On the other hand, it does not take needs and narratives as absolute but interprets and judges them in specific contexts of action.

¹¹ Hall (2005:3)

In terms of the clinical setting, medical treatment and care can overlap but are not the same. Frank (1991:101) argues that when treatment runs out, there can still be care. Hence meaningful life possibilities and a “high level wellness” (Clinebell 1991:211) could be socially constructed in a spiritual and pastoral approach using the narrative therapy. Hence pastoral care with patients regarding them as participants in their healing process opens the door for social transformation as advocated in contextual theology (1:10.1). Transformation goes hand in hand with action that leads to change which is beautifully captured by Isherwood and McEwan (1993: 82) as, “the understanding of acting the faith and not just verbalizing and articulating it.” Therefore the emphasis on the patient’s spirituality captures his or her deepest form of existence. As the pastoral caregiver is confronted with the patient’s spiritual pain as a result of living with HIV and AIDS, it calls on the pastoral caregiver to take a definite ethical stance in favour of the people living with HIV and AIDS aimed at empowering them to believe in their abilities and to become active participants and role players in the process of transformation. In this regard, pastoral care empowers the patients to see themselves as people who are important; as people who have the right to make decisions and to be active participants in collaborating and constructing a better world for people living with HIV and AIDS.

The spiritual and pastoral approach on the other hand emphasizes relationships which are inclusive rather than dominant or submissive. McCarthy (2002:3) is of the opinion that spirituality is fundamentally concerned with meaning and relationships. Such relationships imply connectedness rather than separateness (Graham 1996:28). It is within these relationships that conversations with God take place. The participants in the research were experiencing serious relationship problems with God, spouses, ancestors and others. In the spiritual and pastoral approach, the patient’s conversations with God and their relationship with God is respected. Hence patient’s spirituality may differ from person to person and this calls for a contextual understanding on the part of the pastoral caregiver. Therefore to take into account their context, the narrative therapy (1.12.1.3) emerged as a therapeutic approach which a pastoral caregiver can use to journey pastorally with people living with HIV and AIDS as it values each patient as the knower or expert of his/her life. I also realized that working with people’s local meanings of spirituality and with their personal relationships with God, implied a contextual approach to pastoral care. This resonated well with the participatory action research which requires a

connective understanding that is more than mere empathy, which implied ‘connecting’ with the participants at their level in their context. Furthermore, participatory action research helped me to share power with the participants as co-researchers so I took on the “not-knowing” position to help participants share their experiences without feeling judged or condemned. This is in line with the ethic of participatory care, which is “caring with people” as indicated by Kotze and Kotze (2001:7). In other words, the participants did not depend on me but together we co-created spiritual care with them as the spiritual care receivers and me as the pastoral caregiver. In so doing, spirituality and pastoral care became connected in the journey towards spiritual healing.

In this regard, narrative therapy in pastoral practice, is about “doing therapy respectfully. It is about learning to avoid ways of speaking and listening that unintentionally expresses disrespect for others” (Drewery and Winslade (1997:32). Narrative therapy gives expression to a contextual theology by centralizing patients’ stories and not reducing them to being the passive recipients of expert professionals’ theoretical and classification system. “The more we participate in such a way that the voices of all, especially those who have been previously silenced can be heard, the more we can research and co-construct in an ethical manner, an ethical, just and ecologically sound world to live in” (Kotze 2002:30). The philosophical ideas of postmodern, contextual, participatory and feminist theologies informed my position as well as providing a theological framework for the spiritual and pastoral approach to healing which emerged from this research.

Maximizing the quality of life, engaging to the full the patient and family’s coping capacity, and promoting prevention of infection, all remain central concerns in terms of caring for people living with HIV and AIDS. The achievement of these goals relies at least as much on time spent in one to one or group counselling as it does on medication. Yet how many doctors or nurses can afford to spend more than a few minutes per consultation on a ward, or in an outpatient clinic or can make home visits at all? Rumbold (2002:48) is of the opinion that it is a well-known fact that many nurses and doctors do not have the training skills and desire to spend considerable time counselling patients and their families about their existing issues. Hence, an integrated approach to illness, death and bereavement with a holistic orientation, may achieve far more for people living with HIV and AIDS, as this may increase linkage between the medical, care and support professionals. In addition, Dennill et al (1995:111) describe a multidisciplinary or integrated

health care team as a team whose members represent the widest possible spectrum of individuals and organizations concerned with or involved in any aspect that has a bearing on the health and welfare of the patients in an attempt to provide effective, health care that will assist in the achievement of optimal health for all people. In other words, the aim of the team intervention is to provide a holistic approach to the care of patients, according to their knowledge, that acknowledges the physical, social, psychological, emotional, cultural, economical and spiritual dimension of human life which can improve the quality of life of the patients. In this regard, this research proposes the inclusion of a spiritual and pastoral approach to healing into the primary health care delivery system in Zimbabwe as part of the holistic approach the care of people living with HIV and AIDS.

However, I noted that spiritual care with patients does not guarantee instant and easy solutions. Change does not happen overnight. Many of these discourses, which are so destructive for people living with HIV and AIDS, are rooted in the medical system and require patience and perseverance. A single person cannot achieve this kind of social transformation in the medical system and society. Corporate action is needed as advocated by McDaniel, Hepwoth and Doherty (1992:210), “with more participants as problem solvers, it may be easier to find meaning, to define new dreams and to consider new possibilities for action and relating.” It is my hope that spiritual care will one day be incorporated into the primary health care delivery system in Zimbabwe as part of a holistic approach to the care of people living with HIV and AIDS.

1.3 Motivation

A number of related events motivated me to conduct this research study. These included the magnitude of the HIV and AIDS pandemic in Zimbabwe, the unimaginable suffering HIV and AIDS has brought on people, families and communities throughout Zimbabwe, the desperate search for care and counselling from the impact of AIDS on people’s lives and my personal experience as an HIV and AIDS counsellor in Zimbabwe. My interest in this research is not only academic but arises out of my own context of experience.

As a counselor holding a Bachelor of Science degree in Counselling from Zimbabwe Open University, I was very enthusiastic about offering counselling to people living with HIV and

AIDS. I opened a private voluntary organization where we offered counselling to people living with HIV and AIDS in Gweru Zimbabwe with the permission of the City of Gweru. As we began operating, it didn't take me time to realize that psychological counselling alone was not enough to adequately and effectively address the immense counselling needs of people living with HIV and AIDS. I realized that apart from psychological trauma, people living with HIV and AIDS suffered from existential issues and they asked a lot of questions about why they were in that predicament. My psychological training as a counsellor did not adequately prepare me to address such deep questions that people living with HIV and AIDS asked. In fact, my psychological training did not allow me to talk with clients about God. Hence when the clients asked why God allowed this suffering to happen to them, I didn't know how to respond to that. With that challenge, I was privileged to attend a training course on HIV and AIDS counselling in Uganda at The AIDS Service Organization (TASO). TASO being one of the most experienced HIV and AIDS organizations in Africa it gave me some hope of learning from their experience. I wanted to find out from their experience how they dealt with the spiritual issues experienced by people living with HIV and AIDS. I spent a month at TASO in Uganda in Gulu, one of the regions mostly affected by the civil war at that time. During that time people were still leaving in displaced camps. I learnt a lot from their experience but as I asked the counselors how they dealt with the existential and spiritual issues presented by the clients in counselling, they confessed that they didn't know how to do that except to refer them to their churches. I realized we were in the same predicament. I came home with all the images of suffering I saw in Uganda and I realized I could not continue offering psychological counselling to people living with HIV and AIDS without addressing their questions. At that time I felt my psychology was not adequate. I could not continue operating the organization. I closed the organization and sought for help.

I then enrolled at Stellenbosch University to study for a Masters in Theology in Clinical Pastoral Care HIV and Counselling. The course exposed me to working in some HIV and AIDS clinics in South Africa and during the course of my study the fact that psychology alone cannot adequately address the landscape of immense emotional and spiritual pain experienced by people living with HIV and AIDS was confirmed. This made me realize therefore that, a human being is more than a living document with potentials to self actualizes. During the course of my study, the work of Professor Daniel Louw, a South African theologian who struggles to earth Practical Theology

and pastoral care and counselling to African soil, had a tremendous influence on my training and practice. Louw (1998; 2000; 2005; 2008), is one of the practical theologians who advocates for a theological shift in Practical Theology from a cause and effect paradigm, which implies a rationalistic and positivistic explanatory model, with theoretical answers about the essence of life and the nature of the very being of God to a hermeneutical paradigm. The hermeneutic paradigm endeavors to link God to human life in order to deal with the spiritual dimension of significance and the question of the ultimate meaning of life in the face of evil and suffering which is evident within the HIV and AIDS pandemic.

Louw (2008:37) discusses the impact of a biomedical model on health care and all aspects of caring for the sick pointing out that the advantages of a biomedical model are; accuracy in diagnosis and sophisticated methods of treatment and cure. Nevertheless, medical care has developed to the extent where the patient is no longer the central figure. Louw (2008:38) adds that the danger is that the entire human being can be reduced to a physical, biological or chemical entity to be analyzed and as a result of the power of the physician; the modern scientific understanding of life has gained a pseudo-religious character. Louw (2008:38) continues to argue that a biomedical model holds the real danger that it can easily degrade human beings to the level of mere objects by ignoring their spiritual and cultural dimensions of life. Louw (2008:41) charges that a human person should be regarded as a relational and social being acting within a cultural context making the being of the person more important than the function of his/her body. I concur with Louw's (2008:41) assertion that, because of the tremendous influence of a Western biomedical model in the primary health care delivery system, it becomes imperative to address the issues of health and illness within an African context.

Furthermore through the work of Professor Daniel Louw, I was intrigued to learn that pastoral anthropology can play a significant part in helping caregivers to understand who a human person is and in turn enhance our practice. Louw (2008:15) asks very penitent questions, "what is our understanding of the human person? How do Africans understand the human person?" Louw (2008:116) adds that when one's body becomes ill, one not only has an illness, one is sick meaning disorders of the bodily functions affect the entire person as well as one's sense of identity or ego. Louw asserts that we therefore do not address the ailment or illness of the

patient, or merely the psyche of the person, but the whole person, which is the totality of life within the presence of God. Therefore, with this understanding of the human person, I was motivated in this research to continue to point to the need for a different kind of approach to the care and counselling of people living with HIV and AIDS within the primary health care delivery system of Zimbabwe which can contribute to a holistic approach to the care of people living with HIV and AIDS. I also wanted to know from the participants what their understanding of the human person was and how this understanding can influence the spiritual care of people living with HIV and AIDS in Zimbabwe.

On the other hand, in my Masters in Theology research study, (Tamirepi 2011), the core problem the study sought to explore was the dilemma of the Shona Christians affected by HIV and AIDS in quest to find meaning in their suffering. The assumption was that Shona Christians go back to Shona traditional beliefs and practices in their quest to find meaning from the impact of HIV and AIDS on their lives. The study which was literature based, revealed that HIV and AIDS has greatly challenged both belief systems to such an extent that the dilemma of the Shona Christians in quest to find meaning within the HIV and AIDS pandemic is that, not only do the Shona Christians revert to their traditional beliefs, but they use both systems going back and forth without help, giving rise to a crisis of faith, confusion about who God is and a great damage to their human dignity¹². Hence this dilemma is a reality which has become a daily struggle of meaninglessness and hopelessness for the Shona Christian. As the study was based on literature, this was not enough; it had to be substantiated by first hand experiences of people living with HIV and AIDS themselves. Therefore the current research, to some extent can be linked to this work because of the empirical dimension¹³. I hoped that during this current research journey, I would get an opportunity to hear from the participants about their own struggles in their quest to find healing within the HIV and AIDS pandemic.

1.4 Problem Statement

The primary healthcare delivery system in Zimbabwe largely follows a biomedical model, which seeks to treat patients by focusing on medicines. The psychological models of HIV and AIDS

¹² Tamirepi (2011:106)

¹³ Tamirepi (2011:16-17)

counseling used in the hospital settings also follow the same medical model. This research argues that, the reductionist or mechanistic view of patients as being only material body is no longer satisfactory in addressing the needs of people living with HIV and AIDS. The spiritual dimension of being human in the quest for healing has been consistently overlooked within the primary health care delivery system in Zimbabwe. There has been a puzzling blind spot, a troubling silence and a strange consensus about the role of spirituality in the healing process of people living with HIV and AIDS. This has had the effect of reducing intervention programs to purely medical, psychological and sociological as stated in the HIV and AIDS policy of Zimbabwe. Hence the study sought to correct such an approach by highlighting the role of spirituality in the healing of people living with HIV and AIDS based on a deep appreciation of the value of human life and a holistic understanding of the human person from the participants' perspectives.

In essence, a holistic approach to care is the term often used in official documents relating to hospital services with the understanding that a holistic approach to care addresses all parts of the individual, not just the physical aspects of a person where manifested illness are most apparent. It is an ongoing journey of discovery in search for more answers and ultimately living better. The holistic approach goes far beyond the mind, body connection of finding and maintaining wellness. The point is that, it is the person as a whole that should be cared for all their needs being equally important including their spiritual needs. If this be the case then surely, it is the clinical staff that should be responsible for the patient's mind, body and spirit.

There is now an ample body of research, which explores the meaning of spirituality, the difference between spirituality and religion and the benefits of spirituality in terms of personal well-being and health. For example about 18% of all palliative care journal articles refer to spirituality¹⁴. Flannelly et al (2004:570) often explains the spiritual care tasks and needs that should be addressed in order to die with a sense of completion and peace. Spirituality is widely regarded as beneficial for well-being and peace of mind of those who are ill, ageing or dying including those living with HIV and AIDS (Fawcett and Noble 2004, Koenig 2002, MacKinlay 2001, Taylor 2002). For health care providers spiritual care training is often an exception and

¹⁴ Rumbold (2000), Kelleheir (2002), Mackilay (2004).

spirituality is not included in the curriculum of most formal education and training programmes. Hence the main barriers to providing spiritual care is inadequate staffing, inadequate training of health care professions to detect patients' spiritual problems and needs. The lack of training or confidence in spiritual care giving may be due to several reasons the most obvious one being that spiritual care giving in hospital settings is a relative new field of practice in Zimbabwe in particular and Africa in general.

To this end the unit of analysis this study sought to explore was the lack of spiritual care of people living with HIV and AIDS within the primary health care delivery system in Zimbabwe.

1.5 Research Question

As the HIV and AIDS pandemic continues to unfold in Zimbabwe, it continues to cause unimaginable suffering and agonizing complex problems on the people of Zimbabwe¹⁵. This is further supported by Louw (2008:419) as he states that apart from its physical manifestation as a disease, HIV and AIDS affects the core of what it means to be human raising existential concerns. Persons, families and communities infected and affected by HIV and AIDS experience meaninglessness and hopelessness due to the impact of HIV and AIDS on their lives. In most cases, they blame themselves and feel deeply guilty for having contracted AIDS and possibly for having infected partners or children. They feel separated or punished by God. They are afraid of death! Louw (2008:119) states that HIV and AIDS is a threat to our existence or basic instinct and will to live. Hence because of the resultant weakness and helplessness, illness intensifies the knowledge that one will not live forever. Louw (2008:121) affirms that the fear of death could cause disintegration of one's total existence.

HIV and AIDS confronts patients with their own actions of the past and they begin to take stock and suddenly feel guilty about wrongs committed. They have a guilty conscience and begin searching for a reason or explanation for the illness. Louw (2008:121) adds that often patients view illness as punishment for some or other transgression. They ask questions, "How have I sinned to deserve so much pain?" The guilt is real and must not be ignored or minimized¹⁶.

¹⁵ Jackson (2005), Rodlach (2006), Chitando (2007) and Magezi (2007).

¹⁶ Louw (2008:122).

Ruzindazee (2001:86) adds, “due to the acute sorrow involved in most cases of AIDS, there is always a temptation of looking at this kind of calamity as a punishment from God”.

Furthermore, Louw (2008:419) purports that being HIV positive can become a predicament and a social reality requiring special treatment. Meursing (1999: 37) points out that many people with HIV meet the news of HIV infection with deep fatalism, which is very difficult to dispel in counselling. This implies that being HIV positive brings afore, personal negotiations, compromises and outright surrender of one’s beliefs, customs and practices in a bid to find both physical, psychological and spiritual break through as purported by Bongmba (2007:20). In addition, Louw (2008:126) articulates that HIV and AIDS causes existential suffering which leads to asking the question why me and try to justify the ways of God and His will in the face of the reality. Existential reaction to pain and suffering as well as endurance of pain is spiritual suffering which leads to spiritual outcry and a quest for meaning. AIDS crisis raises the question of theodicy. The pandemic brings enormous personal, emotional, physical, social and spiritual suffering affecting the core of what it means to be human.

In light of what other researchers and literature has highlighted, the main question that the research proposed to answer was:

What could be the spiritual problems and spiritual needs of people living with HIV and AIDS from their perspectives and if any, how could such spiritual needs and problems be addressed within the primary health care delivery system as part of the holistic approach to the care of people living with HIV and AIDS?

1.6 Aim of the research

The aim of this research was to explore the existence of spiritual needs and spiritual problems of people living with HIV and AIDS. This was done in order to co-create a spiritual care approach to healing with people living with HIV and AIDS, which is contextual and relevant to the Zimbabwean context as part of the holistic approach to their care within the primary health delivery system of Zimbabwe.

1.7 Research Goals

The goals of this research were:

- To develop an understanding of the spiritual needs and problems of people living with HIV and AIDS who are receiving care within the primary health care delivery system.
- To investigate the spiritual root causes of HIV and AIDS and their role in the quest for healing from the perspectives of people living with HIV and AIDS.
- To search for an understanding of the role that traditional beliefs and customs play in people's perceptions towards the Western epidemiological understanding and interpretation of the HIV and AIDS pandemic in Zimbabwe.

1.8 Proposed future use of the research

In future, the research may;

- Contribute towards the inclusion of spiritual care and counselling into the primary health care delivery system as part of the holistic approach to the care of people living with HIV and AIDS.
- Contribute towards the development of spiritual care training programmes, which are contextual and relevant to the Zimbabwe context in institutions of higher learning.
- Contribute towards the amendment of the care and counselling policy of people living with HIV and AIDS in Zimbabwe with the inclusion of spiritual care and counselling.

1.9 Contribution to Practical Theology

The study hoped to be a contribution to theology in general and to pastoral care in particular, in the context of caring for people living with HIV and AIDS. This challenge relates to making pastoral care and counselling relevant, contextual and optimally effective within the Zimbabwe context. Pastoral care and counselling can be optimally effective in the Zimbabwean context within the HIV and AIDS pandemic provided;

- It ceases to be a duplicate of European and American pastoral care and counselling.

- Pastoral care and counselling acknowledges the African realities of interpreting and understanding of HIV and AIDS.
- Pastoral care as spiritual care is integrated into the primary health care delivery system and not only as a ministry within the church but as part of the clinical practice.

The research focused on how the spiritual care needs of people living with HIV and AIDS could be addressed within the PHC delivery system in Zimbabwe within a practical theological framework. In addition the research aimed to be a search for a spiritual care approach to healing that is relevant in the context of HIV and AIDS. This research made effort to study HIV and AIDS within the PHC delivery system from the experiences of people living with HIV and AIDS themselves by listening to their stories of pain and suffering. Martey (1993:7) calls this theology from the “underside of history” and it will be a theology born out of the struggle. Martey (1993:7) states, “For those coming from the underside of history, theology has always been a struggle against all enslaving and dehumanizing forces.” Consequently, pastoral theology (theory) and pastoral practice which developed in Zimbabwe specifically and in Africa generally, remains subject to the cultural tutelage of the first world (developed world) where HIV and AIDS and other social ills and problems are not only confined to theological disciplines. In making this case the alternative view in terms of caring for people living with HIV and AIDS, which I explored with people living with HIV and AIDS was not recycled Western ideas. In the context of HIV and AIDS, the problems that beset Africa are different from those experienced in the West (See Chapter two). Faith Based Organizations (FBOs) and some Non-Governmental Organizations (NGOs) in Zimbabwe offer pastoral care and counseling based mainly on the West and funded by it, which again raises serious questions about whose interests they serve. Hence it became imperative to carry out this research aimed at developing a spiritual care approach which is relevant and contextual to the people living with HIV and AIDS in Zimbabwe.

1.9.1 Pastoral Care as a sub-division of practical theology

According to van der Ven (1993:37) pastoral care is one of the sub-disciplines of practical theology, which in the past was referred to as shepherding, poimenies and social care. In the past it was confined to pastors and priests as if they were the only ones to take care of others. The

discipline has developed to the extent that it is liberated from individualism and clericalism to professionalism of which I am part of as a clinical pastoral caregiver. This research argues that pastoral care is largely and primarily a Western dominated enterprise. Theories generated for this field are influenced by individualistic and affluent lifestyles of Western, European and North America.¹⁷ Louw (1995:29) adds that pastoral care is mostly oriented to the European and North American mode and the pastoral care theories used at our universities and theological seminaries are imported into Africa often without adaptation for the African context and culture. In addition, Njumbuxa (1995:47) adds that Western oriented pastoral care as we have it appeals best among Western oriented people. Hence, Louw and Njumbuxa warn that pastoral work should not be viewed as a carbon copy of the white pastorate. I found this argument very persuasive and could be reconciled to this study. My conviction in this regard is that whereas pastoral care in Africa cannot completely sever ties with its heritage, it needs to be critical and to take cognizance of the context in which it is developed and practiced. Msomi (1993:75) argues that, “the weakness in the Southern African context has persisted for too long as the African pastorate was a carbon copy of the European, British or North American one.” If pastoral care is to be contextual and relevant to the African people, this is an anomaly which must be corrected. This research is a contribution in this endeavor. In light of this critique, as one trained in the Western oriented pastoral care, I was curious to find out through this research journey how I would take cognizance of the Zimbabwean context in general and the HIV and AIDS context in particular as I collaborated with people living with HIV and AIDS. The philosophical ideas from postmodern, participatory, feminist and contextual theologies had a lot to offer in this regard. I shall elaborate on these theologies later (1.11). Therefore, this research was also done in view of contributing towards making pastoral care contextual and relevant to the African people making it “optimally effective¹⁸”. In the next section, I discuss pastoral counselling as a division of pastoral care and within it. I also describe clinical pastoral care, which is very much linked to this research.

¹⁷ Gerkin (1997:15) concedes that the development of his narrative hermeneutical model was influenced by Anton Boisen who was the first person to coin the phrase the “living human document”. In this model there is due recognition and appreciation of the importance of human needs in pastoral care. Gerkin (1997:97) comments that this phrase, “the living document” is Boisen’s way of reminding us that any human being is a unique text that must be read and interpreted as we carry out our hermeneutical task.

¹⁸ Cpaas (2003:9) and Stevenson-Moessner (2005:23)

1.9.1.1 Pastoral counseling

Pastoral counseling is one dimension of pastoral care. Pastoral counseling as described by De Jongh van Arkel (2000:33) is, “a more specialized problem oriented caring action in its focus on people with problems however pastoral counseling is different from other counseling approaches because it integrates insights from psychology/behavioral sciences, theology and spirituality.” De Jongh van Arkel (2000:108) further asserts that pastoral counselling is a caring action directed at individuals, couples, families and groups “who are experiencing serious problems in their relationships with others, themselves and with God.” Hence the contextual, political, structural and economic dimensions should be taken into account. In this research, I found all the above ideas about pastoral counselling working because firstly I was able to integrate insights from psychology, theology and spirituality as I worked with the participants through their spiritual pain because of my former training in psychological counselling and theology. I was also able to integrate insights of the participants’ spirituality in doing spiritual care with the participants.

Kotze and Kotze (2001:3) say that pastoral counselling is a “commitment to transformation, positioning oneself on the side of those suffering and against all oppressive or exploitative discourses and practices.” This provoked me as a pastoral therapist to take a definite ethical stance in favor of the people living with HIV and AIDS against the disempowerment and isolation discourses and practices they have experienced in society. Hence social transformation was aimed at empowering the people living with HIV and AIDS to believe in their abilities and to become active participants and role players in the process of transformation in terms of their healthcare. In this regard the participants requested for their spiritual well being to be considered within the primary healthcare delivery system in Zimbabwe.

In terms of pastoral counselling, Reeter (1984:34) postulates that all over the world “the comment is made that this is hard work and the work that mental health professionals would often choose to avoid.” As I listened to the participants’ stories of indescribable pain and suffering, I found myself transported to places and into territories of life and identity/meaning that I had never imagined before. The narrative ideas of doing therapy helped me to realize that we were in this together with the participants and I did not need to have answers to all their

questions. My experience during the research journey reminded me of how White (1995:7) describes therapy;

Therapeutic interaction is a two-way phenomenon. We get together with people for a period of time over a range of issues and all of our lives are changed for ever

The ‘not-knowing’ position helped me to enter into the participatory mode of consciousness¹⁹ which resulted from my ability to let go of all preoccupation with self and more into a state of complete attention. In this manner, I made a faithful offering of myself to the participants. In the next section, I describe clinical pastoral care, which is specifically related to this study as a division of pastoral care

1.9.1.2 Clinical pastoral care

Clinical pastoral care involves exploring the spiritual definition of the situation/problems from the patients’ perspective²⁰. In this regard clinical pastoral practice acknowledges the social production of knowledge in response to the emotional and/or spiritual needs of patients and families in health care emergencies and other situations. Clinical pastoral care is not limited to, ordained clergy and other counseling professionals. Hall (2005:3) adds that it is about transformation of hospital chaplaincy into spiritual care services hence it diagnoses with a theological and spiritual perspective. It is universally relevant to all patients and not just ‘religious patients’ and the unique contributions of a theological perspective distinguish it from psychology.

In order to achieve the aim of the research and to answer the research question, the philosophical ideas of postmodern, contextual, participatory and feminist theologies informed my position as well as provided a theological framework for the research. Exploring these approaches provided a backdrop to the understanding of stories of the co-researchers’ lives, relationships, experiences and contexts within the HIV and AIDS pandemic in Zimbabwe. The theological and philosophical stance shaped my interactions with the research participants.

¹⁹ Heshusius (1994:17)

²⁰ Woolger (1983:244)

1.10 The theological framework of the research

This practical theological research journey was informed by the philosophical ideas of postmodern, contextual, participatory and feminist theologies. According to Anderson (1997:94), a philosophical stance refers to a way of being in relationship with our fellow human beings, including how we think about, talk with and respond to them; it reflects an attitude and tone that serve as the backdrop for my relationships with clients and the therapy process, and how I locate myself in a conversation. A philosophical stance therefore represents a way of looking and experiencing the world and it is inevitably influenced by our values and biases. “It is a metaphorical position in which our social and personal attributes are convened” (Anderson 1997:94). I discuss how contextual and participatory approaches to practical theological practices empower pastoral care in our changing, fragile and ever-changing postmodern time. I explore what the transition to a postmodern worldview has to offer to practical theological reflections in the context of caring for people living with HIV and AIDS. I describe how the research journey was also informed by feminist theology in various ways, as feminist theology provided an epistemological base for the interpretive, dialectic, gendered and political aspects that make up this research and forms an important part of the theological framework of the research.

1.10.1 Contextual approach to practical theology

The title of the research, *HIV and AIDS within the primary health care delivery system in Zimbabwe: A quest for a spiritual and pastoral approach to healing*, demanded the focus on a concrete context. I chose to position this practical theological study in agreement with a contextual local perspective. I created a space in the conversations with the participants that welcomed the plurality of meanings attributed to the concept of spirituality. The very essence of practical theology demands of it to be very focused on concrete contexts, which are always local, concrete and specific. Practical theology is only possible as contextual practical theology since practical theology cannot function in a general context. Hence, McEdwan (1993:73) describes contextual theology in the following manner, “out of our contemplation of the divine, we reflect on the concrete situations in which we see ourselves and other people and this leads to our making theology which in turn has to be tested against concrete realities”. The research participants’ questioning of God about their spiritual pain and suffering led to reflective

conversations on who God is and how He was linked to the spiritual pain experienced by the participants from their perspectives.

I also chose a contextual approach of doing practical theology in this research because it starts from the life situation of people and proceeds from there to reflection. Roux et al (2003:51) asserts that, the term “contextual” suggests that the current situation is taken into account and the word is “generally associated with a strong socio-political awareness”. To me this is a grass roots approach rather than a top-down attitude that leads to action. This form of practical theology, with its “from below” communication style, suggests that communication should involve the experiences and expectations of people living with HIV and AIDS themselves²¹. This implies that theology can only be done credibly if it is done with those who suffer and the emphasis is on ‘doing’ theology. My commitment to people living with HIV and AIDS as the first act of theology was especially important as this validated how the spiritual care needs of people living with HIV and AIDS could be addressed within the health care delivery system in future. Hence the theological conversations entailed a “talking with” an “in there together” process in which the spiritual issues at hand were co-explored towards resolution and hope²². From a contextual perspective it becomes impossible to do theology as though we live in some abstract realm or dead corner of history (Isherwood and McEwan 1993:77). Truter and Kotze (2005:975) point out that it is in this way that we approach pastoral care as a means of respecting the patient’s unique descriptions and experiences of his or her own illness. In this way, pastoral care with patients strives to find new ways to involve the community and medical system so that patients can be accommodated and their stories centralized and respected.

In this research, the contextual approach to practical theology was also employed in the documentation of the research journey because it voices the reflections of the people of God living with HIV and AIDS from below as they live their lives of faith and care in the specific context of Zimbabwe.

²¹ Rossouw (1993:900)

²² Collect (2003:22)

1.10.1.1 Knowing is Contextual

Astley (2002:59) states that from a postmodern epistemological perspective, reality is not perceived as an objective given but instead knowing is seen as inherently contextual “because within this approach the knower helps constitute what is known.” Roux et al (2003:46) add that the socio economic and socio political realities of the co-researchers will therefore be decisive for the co-construction of knowledges as they constitute the “readily available possibilities of what we can know and how we can know”. Astley (2002:3) argues that we must therefore acknowledge that theology is always contextual as it is set in some context and rooted in some life experience or issue. In this research, I presupposed that by drawing on the experiences of people living with HIV and AIDS, in the particular of their culture and historical situation, theology is of necessity contextualized²³.

In essence practical theology studies religious praxis as it relates to the encounter between God and human beings. In this research, I was interested in finding out how people living with HIV and AIDS related their experiences of living with HIV to God. I listened for clues in the people’s narratives about their experiences of God in this regard. This was done being mindful of Muller’s (2005:11) assertion that, “this is not a forced effort by the researchers to bring God into the present situation, it is an honest undertaking in order to hear and understand the co-researchers’ religious and spiritual understanding and experiences of God’s presence.” As the participants in the research told their stories, I was interested to know how people living with HIV and AIDS are encountering God in their lives. I wanted to know from them who God was to them. In so doing, I realized that the participants experienced God differently and their spirituality emerged as a vital resource in their healing process. Hence the spiritual and pastoral approach to healing which the study proposes, acknowledges the importance of including the people’s spirituality in doing spiritual care with people living with HIV and AIDS.

²³ O’Brien (2001:292).

1.10.1.2 Voicing Change

A contextual approach to practical theology refuses to endorse a view that sees the world in which the care of people living with HIV and AIDS as “static” as something that “only has to be explained but rather “sees it” as something that has to be changed²⁴. Hence the strong suggestion which emerged from the research was that spiritual care must of necessity be integrated into the primary health care delivery system and this may lead to social transformation of the quality of care being offered to people living with HIV and AIDS. This research was aimed at hearing those unheard voices of people living with HIV and AIDS as the experts of their lives, providing them as theologians full participation in interpreting their experiences of God within the HIV and AIDS pandemic. I am convinced that, as much as people living with HIV and AIDS as marginalized persons themselves take up their rightful place as interpreters of their own experiences this research does constitute practical theology and may help empower the participants for social transformation which may lead to the inclusion of spiritual care into the PHC in Zimbabwe. This is where theology is understood as a two-way conversation between culture or context and the Christian faith or Scripture. In this research, co-creating spiritual care which is sensitive to cultural embeddedness, pastoral care then fulfilled the role of networker and bridge builder in order to hold both worldviews in a creative and dynamic tension where the complex interrelatedness and interconnectedness of the two worldviews interacted in the process of doing spiritual care with people living with HIV and AIDS.

1.10.1.3 Doing Theology

Within the contextual approach to practical theology, ‘doing theology’ or spirituality must be ‘done with those who suffer and ‘doing’ is more important than knowing or speaking. De Gruchy (1994:12) states that ‘doing theology ’can never be a neutral exercise or can it be a substitute for faith and commitment’. My commitment to people living with HIV and AIDS became the point of departure for me in ‘doing theology’ as spiritual care with the participants as co-creators of the healing process.

²⁴ Bosch (1991:424).

1.10.2 Participatory approach to practical theology

Kotze and Kotze (2001:5) asserts that a participatory approach to theology refers to a shift from the general to the local, from mainstream Western theology's claim of universal validity to true participation among all participants of practical theology. A participatory approach to practical theology links with the ideas of the contextual social construction and postmodern approaches with an emphasis on inclusion, participation and a practicing theology rather than constructing a theology. This position ensures that practical theology is contextual. On the other hand, a participatory approach to practical theology takes the ethical position of introducing previously unheard voices to the realm of theology. As such, the stigmatized and marginalized voices of people living with HIV and AIDS can now be heard in the research. I am convinced that within this practical theological approach the co-researchers and my own unheard voice, as the voices of the so called non-theologians will have a contribution. In the research journey with people living with HIV and AIDS I accepted the presence of difference and otherness in experience. I listened to their unheard voices and completed these voices constructively. I ensured that there was space in the telling of the people's God as they experienced their God. God became an integral participant in the conversations, but it was not possible to control or pin down his/her participation. In such an approach there would be no need to come to conclusions and to define beliefs in a set of statements or doctrines but to care with the participants.

Roux et al (2002:66) asserts that the doing of practical theology within a participatory approach reaches beyond a mere practice of theology. This participatory approach refers to a shift from the 'general to the local and from Western Theology claiming universal validity (Kotze and Kotze 2001:5) to true participation among all participants of practical theology (Roux et al 2002:66). Hence as the participants were positioned as the experts of their lives, we co-researched and co-created spiritual care and their local knowledges became very valuable.

1.10.2.1 Knowing is local

The contextual nature of the participant's knowledges has already been explored above; hence it is clear that with these knowledges, it is impossible to voice large truths. All one can do is to

voice local truth and propose that it pertains elsewhere²⁵.” A participatory approach to practical theology acknowledges the local character of knowledge and therefore of theology as well. As a result, this research journey does not claim to inform anyone of large truths that will be appropriate for all people living with HIV and AIDS in all contexts at all times in terms of addressing their spiritual problems and spiritual needs within the PHC.

Astley (2002:56) uses the phrase “ordinary theologies” as his term for the theology and theologizing of people who have received little or no theological education of a scholarly academic or systematic kind. Hence the participatory approach to practical theology not only recognizes the local nature of knowledge, but also the local theologies of participants and the contractedness of theology within individual communities. Roux et al (2002:62) point out that participatory practical theology is not “something out there that we discover but something we construct with our local religious or spiritual community” and this was the aim of this research. The local nature of knowledges was acknowledged as well as the local theologies. In order to achieve this, what postmodern theology had to offer to practical theology became imperative to pastoral care in specific.

1.10.3 Postmodern theology

A postmodern paradigm challenges many of the meta-narratives that are supposedly universal, absolute and ultimate truths and are often used to legitimize various political and scientific projects²⁶. A postmodern paradigm can help us to view postmodernity as a vital opportunity that creates a climate however risky, that will “revitalize spirituality” where faith is no longer an embarrassment as it was in the modern world, where faith was seen as something one settled for when one could not have scientific evidence²⁷. In addition, Caputo and Scanlon (1999:11) assert, “In the modern period religion was ignored, tolerated, repressed and (sometimes without reason) persecuted. But today, we witness a massive return of religion with all of its ambiguity together with a return to God to the centre of theology”. According to Gergen (2009:6) various traditions of truth are simply optional. In the research journey the participants as people living with HIV and AIDS brought God back to the centre of theology by first questioning God about

²⁵ Bruggermann (1995:9)

²⁶ Appignanesi and Garrat (2003:103)

²⁷ Botha (1998:399)

their spiritual pain and later as they acknowledged God as their healer. There was a revitalization of the participants' spirituality as a forgotten resource, which could be used in their quest to find healing.

I was curious in this research journey to find out how people living with HIV and AIDS could use their faith or spirituality as part of their healing process without any embarrassment as it were in the modern world, where faith was seen as something one settled for when one could not have scientific evidence. McLaren (2000:178) is of the opinion that "in the postmodern world, it seems, everyone lives by faith." Therefore, a postmodern framework to practical theology in this study required a critical stance towards knowledge including knowledge about spiritual matters, knowledge and truth which are considered to be pluralistic, temporary, local and contextual. The participants' stories were used in this work to acquire "knowledge" about the experiences of people living with HIV and AIDS in Zimbabwe

Therefore, this practical theological research was also positioned within the frame of the postmodern theology where "every person imagines God personally and differently although this does not exclude the religious feeling that my God is also your God²⁸." Bons-Storm (1996:130) asserts that as such God is therefore seen as "Divinity-in-Diversity female / male, black /white and so forth." In this research, I was open to new ideas and views on God because I am convinced that each person's relationship with God is unique. With this in mind we need not be passive recipients of God's plan for us "all people are afforded the right to some human input that co-determines the "plan" for their lives²⁹. Tong (2004:15) asserts that the potential for spiritual growth is so much greater when people actively engage in the spiritual meaning and making of experiences in their daily lives.

Being conscious of what Botha (1998:400) calls the "fluidity of our postmodern epistemology", I could not "absolutise the postmodern condition" as doing so would be taking "modernistic social construction discourse as epistemology³⁰." But as postmodernity is our cultural context the now we are living in, I reflected on and in the fluidity of these changing times. Herholdt (1998:453) is of the opinion that postmodern practical theological research opens the possibility of questioning

²⁸ Herholdt (1998:225).

²⁹ Hermoldt (1998:217)

³⁰Botha (1998:400).

modernism's authority and claim to universal knowledge and of establishing the central position of the researcher in actively and participative constructing the meaning of the text from the perspective of the social context. It also recognizes that instead of some universal humanity, differences between people exist and that these differences need to feature in how we as people engage with one another in ethical ways of caring for people living with HIV and AIDS.

Giroux (1997:193) argues that postmodernism raises questions and problems so as to redraw and re-present the boundaries of discourse and cultural criticism'. This research intended to also question the boundaries of knowledge about pastoral care and counseling with a view to redrawing them in order that they could become relevant to the spiritual care needs of people living with HIV and AIDS in Zimbabwe. In this way, this research also intended to shape the discourse about 'pastoral care' itself. The co-researchers in this research are people living with HIV and AIDS who live in a multi-cultural and multi-religious country. At a very specific time in the history of Zimbabwe, "when old habits are hard to break and hope is still fragile³¹". In the gap between breaking old habits of caring for people living with HIV and AIDS and finding ourselves in a new era where there is a need for more research to find alternative ways of caring and counseling people living with HIV and AIDS considering the complexity of problems HIV and AIDS has caused on the people. Hence, the notion that what one is able to see depends on one's observational set up (Deist 1994:260) is made real in this research by a feminist theological epistemology that recognizes how marginalized positions in this case people living with HIV and AIDS, can offer new insights to practical theology and pastoral care.

1.10.4 Feminist Theology

As a Shona Seventh Day Adventist woman, I was interested in choosing a theology that is relevant to my situation. Kotze and Kotze (2001:6) assert that feminist theology represents a radical critique of patriarchal religious and theological thinking with the result that women and men benefit through this kind of partnership. I agree with the notion that feminist pastoral practices are liberating as they seek justice, peace, healing and wholeness for all in partnership as pointed out by Ackermann (1991:96). Feminist theology aims at moving the voiceless and the hidden into the centre of theology. This challenged me to move from "being right to doing right"

³¹Ackermann 2001:63)

or to go beyond the luxury of merely thinking commitments, to doing commitments with people living with HIV and AIDS³².

The research journey is also informed by feminist theology in various ways as it resides within the contextual approach to practical theology. According to Ackermann (1991:107) the aims of feminist liberation theology are ‘critique, correction and transformation’. This approach to theology is an obvious choice in light of the title of the research journey. Ackermann (2003: xvi) points out that feminist theology starts by looking at social reality by recording stories. Ackermann (2003: xvi) asserts, “Narrative is the lifeblood of this kind of theology for it is in stories that the validity of a host of very diverse experiences is found”. Consequently, the people living with HIV and AIDS were given an opportunity to “contribute to the dialogue of faith” as stated by Bons-Storn (1998:23) by sharing their narratives. According to Fulkerson (1994:13) feminist theology allows a variety of people to tell their stories and to write theology from their own perspective. Ackermann (2003: xiii) points out that feminist theology is rooted in its, “social and political context” which is in constant dialogue with the recent history of Zimbabwe in this regard. In line with postmodern thinking, feminist theology with its contextual values therefore aspired to address the spiritual needs of people living with HIV and AIDS at a particular time, in a particular country and with particular challenges.

The research was documented through the lens of feminist theology, because it was committed to “participating in solidarity with all who struggle to find healing and freedom³³.” I agree with Ackermann’s (2003:xvi) view that theology is an ‘organic enterprise, one that is close to the ground, that can nurture the fragility of our lives as we struggle to put out shoots of new growth’. In the search for meaning we need to test the evidence ‘from below’ in contestation of truth. I am convinced that what a feminist hermeneutic added to this practical theological research what neither contextual theology nor liberation theology can offer is its link with post-structuralism analysis. This enabled me to take a critical look at the ways in which power relations are structured and analyze the ways in which these are maintained by certain discourses that legitimize the control of some people by others. According to Denzin (1989:248) feminist theology provides an epistemological base for the interpretive, dialectic, gendered and political

³² Kotze and Kotze (2001:5).

³³ Ackermann (2003: xvii).

aspects that make up this research and forms an important part of the epistemological framework of this research. In my research approach, I subscribed to a feminist theology of doing theology in which the lived experiences of people living with HIV and AIDS within the PHC become centralized.

Poling (1991:129-142) highlights the contribution that feminist analysis of societal discourses and their impact within the HIV and AIDS pandemic has made to the development of a pastoral praxis that is sensitive to the presence of power relations. Because of this sensitivity, it becomes possible to listen for and hear not only the voices of those who are living with HIV and AIDS but the societal mechanisms of power that maintain and sustains the HIV and AIDS pandemic in Zimbabwe. Isherwood and McEvan (1993:33) affirm that the experience of women and men and their interaction with each other and with society is a source from which to do theology. So too, I took cognizance of these facts as I did spiritual care with the co-researchers. In line with the above discussion, the following section discusses the theoretical framework, which also informed the research journey.

1.11 Theoretical Framework of the research

Hence for the theoretical framework of the research journey, I chose postmodern philosophical ideas as an epistemology of this study because it acknowledges that objective knowledge is impossible and therefore multiple realities are preferred since there are no universal criteria for the truth claims to knowledge, which are always contextual. I also describe social construction discourse as a page from the postmodern text and it became a lens for knowledge I employed throughout the research journey in investigating and exploring how the spiritual problems and needs of people living with HIV and AIDS can be addressed within the primary care delivery system in Zimbabwe in the postmodern times we live in.

1.11.1 Postmodern epistemology

I chose postmodern ideas as an epistemology of this study because of the stand it takes regarding reality, especially in terms of what constitutes knowledge and how and for whom knowledge is

constructed³⁴. Kotze (1994:21) adds that postmodern epistemology holds “the idea that objective knowledge is impossible”. Therefore multiple realities are preferred. Brueggermann (1993:9) adds, “there can be no objective facts no single truth, that reality is not something that can be constructed irrespective of its knower but that the socio-economic, political reality of this knower is decisive for knowledge.” Zuber-Skerrit (1996:68) affirms that there are no universal criteria for the truth claims to knowledge, which are always contextual.

Within a postmodern framework, knowledge acquisition by means of subjective influences is regarded as its greatest strengths, the more subjective the information; hence the closer it is to representing the lived experiences of people living with HIV and AIDS. White (1995:66) states that a reflexive mode of knowledge acquisition challenges the researcher in terms of his/her own settled certainties in so far as we cannot “know” in advance what is right for the participants. Heshusius (1994:206) points out that, the research process becomes one of collaborative dialogue “a letting go of boundaries” that constitute the self and construct the perception of distance between myself and the participants involving a participatory mode of consciousness. In this research, the knower and the known interacted and shaped one another in co-creating spiritual care which is relevant, contextual and optimally effective in addressing their spiritual needs. The fact that knowledge is subjective as it involves the context and the knower, suggests that reality is a social construct. I will discuss social construction below.

1.11.2 Social construction

Gergen (1994:24) as the primary developer and one of the most influential theorists of social construction describes it as the “full blown successor project that is replacing empiricist and rationalist human sciences whose foundations has been shaken.” Gergen (1994:7) argues that within social construction philosophy, explanations of the world are not driven by what there is but rather have their origins in human relationships. Gergen (1994: 29) further illustrates that social constructionism is an epistemological and not an ontological theory, it does not make claims about the nature of private experience of physical reality but about the process of expressing and making sense of private experience with physical reality. Later on, Gergen

³⁴Richards (1990:12).

(2001:2) describes social construction discourse as a “page from the postmodern text”. Having laid out the theoretical framework, it is now possible to see what some of social constructionism’s implications are for this research. Social constructionism is a lens for knowledge I employed throughout the research journey in exploring how the spiritual needs of people living with HIV and AIDS could be addressed within the primary health care delivery system in Zimbabwe in the postmodern times we live in. Social constructionists have no difficulty with “locally claimed realities as these may be anticipated and honored³⁵.” The locally claimed realities of people living with HIV and AIDS who shared the act of documenting the research journey in various capacities were therefore honored by giving them a chance to speak as theologians in this academic discourse.

The heart of social constructionism is the idea that our possibilities as human beings arise from the culture, society and tradition with which we live, we construct-socially, together through history, what we define as real and true³⁶. In this regard I became interested to understand from the participant how they defined HIV and AIDS and what were true and real to them about the disease. Therefore, social constructionism inquiry is principally concerned with explicating the process by which people come to describe, explain and otherwise account for the world in which they live³⁷. To this Freedman and Combs (1996:16) affirm that realities we take for granted are the realities that our stories have surrounded us with since birth. The ways in which the people living with HIV and AIDS understood the world of being HIV positive, the categories and the concepts they used were historically and culturally specific³⁸. It is my supposition that social constructionism is suitable for hermeneutics and for understanding the human map-making as systemic in nature³⁹. I also found it suitable because it promotes disclosure in the way in which it provides space for the “challenge of communicating across the boundaries between different denominations and different religious communities⁴⁰”. Schnitzer (2002:176) further points out that in order to enter the space of intercultural and inter-religious communication, it is necessary

³⁵ Gergen and Gergen (2003:228).

³⁶ McLeod (2004:351)

³⁷ Gergen (1985:266)

³⁸ Burr (1995:5).

³⁹ Gergen (2002:283).

⁴⁰ Schnitzer (2002:176).

that “tolerance, mutual respect, and even appreciation of the other be present.” Hence throughout the research journey I maintained this position.

Kotze (2002:9) asserts that within social construction discourse, knowledge no longer represents the world as it is, but is now taken as referring to our interpretations, resulting in realities that are socially constructed by people in specific contexts, with specific purposes and with real political and ethical efforts. Therefore, the narratives of the co-researchers invited collective dialogue from which new futures could be created in terms of addressing their spiritual needs within the primary health care delivery system in Zimbabwe. I was convinced that this research journey would spark such a dialogue as its contribution to society by providing readings and lenses of understanding that invite and include everyone as participants collectively to make new meaning⁴¹ and co-create a new future through conversations in terms of caring for people living with HIV and AIDS. Louw (1997:27) describes the task of practical theology as that of creating a healing community, where painful stories of the past can be hold and heard. In this study, the participants as a group formed a healing community where each participant was able to share his/her life experiences of being HIV positive without the fear of being judged or condemned and this was the beginning of their journey towards spiritual healing.

The research journey sought out ways to give a voice to the spiritual problems and needs of people living with HIV and AIDS through their narratives and to honor their contributions as knowledges that were worth listening to. Hence my assumption was that individual minds are not the source of knowledge, but the communities as people in relationships. Gergen (2003:3) adds that individual knowledge on this account is not a private achievement but owes its origins to community participation. Social constructionist inquiry is principally concerned with explicating the processes by which people come to describe, explain or otherwise account for the world (including them) in which they live. From the constructionist position the process of understanding is not automatically driven by forces of nature, but is the result of an active, cooperation enterprise of persons in relationship⁴². In essence realities are socially constructed. Knowledge is performed not found. Knowledge is constituted through language. Realities are organized and managed through narratives. There are no essential truths. In other words, just as

⁴¹ Hoffman (1997:xii)

⁴² Gergen (2003:15)

human beings evolve their own languages and create their intersubjective meanings regarding their daily experiences through dialogue, so people generate meanings surrounding their spirituality. Hence from a social construction perspective, an individual's spirituality is regarded as being constructed in conversations in the social networks in which the individual finds him/herself. McCarthy (2002:3) is of the opinion that spirituality is fundamentally concerned with meaning and relationships. Hence the role of language and relationships in the constructions of meaning are emphasized in a social constructionist approach.

Illness and self are social constructs linked to social norms, values, socio-economic and political factors. Illness and self will differ across context and culture and will be based on the cultural and contextual standards of abnormality. Health and illness are perceived to exist as extremes on a continuum because neither is purely the ideal when it is located in reality. Hence, in this research I wanted to know from the co-researchers as people living with HIV and AIDS how they understood the disease themselves as Zimbabweans. I wanted to know from the participants what they considered to be their spiritual problems and needs. I wanted to know from them how they understood the human person and how that knowledge could influence the spiritual care of people living with HIV and AIDS.

1.12The research methodology

The research endeavored to investigate the spiritual problems and needs of people living with HIV and AIDS as well as exploring how these spiritual problems and needs could be addressed within the primary health care delivery system in Zimbabwe. In line with this research question, the aim of the research study was to co-create spiritual care with the people living with HIV and AIDS which was contextual and relevant. In order to answer the research question and achieve the aim of the study, an empirical dimension of the research had to be done with the research participants as co-researchers. This is in line with what Van der Ven (1988:13) posits that what is needed in practical theology is empirical theological research where the procedures of conceptualization, operationalisation and data collection determine the praxis under investigation. In the same vein, Pieterse (1994:79) points out that in the empirical approach, practical theology finds methods and tools to describe and explain what goes on in the lives of people. The research consolidated what emerged from literature with the empirical dimension of

the research that was conducted with people living with HIV and AIDS who are receiving care and counseling within the PHC. However the participants became the primary sources of data presented in this study because they were regarded as the experts of their lives. Louw (2008:17) affirms that without any doubt, the empirical dimension helps Practical Theology to refine theological interpretations. At the same time it helps pastoral care to focus more adequately and effectively on existential life issues. In the same vein, to reach reliability and validity of the research goals, the empirical dimension of this research is important. This is supported by Mouton (1996:78) when he states that the pursuit of valid knowledge, the scientific inquiry drives research to arrive at the results that are close to the truth as possible. Therefore, the researcher's aim with the empirical dimension was to generate information at primary level. The reason is that actual worldviews of the people can only be falsified or validated by obtaining first hand information from the concerned parties. This was viewed in terms of co-creating spiritual care which is relevant and contextual to people living with HIV and AIDS as part of a holistic approach to their care within the primary health care delivery system in Zimbabwe. This research is therefore a contribution to the existing body of knowledge that makes pastoral care and counselling contextual.

I chose to do qualitative research and knowing that qualitative research is broad, I preferred participatory action research (PAR) with people living with HIV and AIDS for its values that all people have the capacity to think and work together for a better life. PAR was done through the therapeutic lens of the narrative approach as it could be considered to be a postmodern, poststructuralist form of research and therapy positioned within the social constructionist domain. Hence the following section outlines the research methodology for this practical theological research journey.

1.12.1 Qualitative research methodology

Linton and Mowat (2006:29) describe qualitative research as a broad umbrella term for research methodologies that describe and explain person's experiences, behaviours, interviews and social contexts. In line with this thought, Willig (2001:9) adds that qualitative researchers study people in their own territory, within their naturally occurring settings e.g. home, schools or hospitals, which are open systems where conditions continuously develop and interact with one another to

give rise to a process of ongoing change. Willig adds that qualitative research takes human experiences seriously and seeks to understand the meanings people ascribe to phenomena and experiences assuming that human beings are by definition interpretive creatures that make sense of the world and their experiences in a constant process of interpretation and meaning seeking. Linton and Mowat (2006:30) further elaborate that identifying and describing understandings of these meanings is the primary task of qualitative research. Hence qualitative research deals with ideographic truth (knowledge discovered through unique, non-replicable experiences). It seeks to understand and interpret such experiences. Therefore, as stated by Willig (2001:9), qualitative researchers do not tend to work with variables that are defined by the researchers before the research process begins. Qualitative research stresses the socially constructed nature of reality, which is contextual and specific and they do not intend to capture objective reality. They seek answers to questions that stress how social experiences are created and given meaning⁴³. This orientation in qualitative research corresponds with the social constructionist approach (1.11.2) which led me to investigate what the spiritual problems and spiritual needs of people living with HIV and AIDS are and how they could be addressed within the primary health care delivery system in Zimbabwe.

Furthermore, Linton and Mowat (2006:35) posit that qualitative research can provide three types of knowledge (a) knowledge of others: understanding how individuals or groups view and interact with the world, (b) knowledge of phenomena: what certain practices mean to people and (c) reflexive knowledge: the role of the researcher in constructing the world he/she is researching. Willig (2001:10) points out that qualitative researchers tend to be concerned with the quality and texture of the experience rather than with the identification of the cause-effect relationships. They aim to understand what it is like to experience particular conditions e. g in this case, what it means and how it feels to be living with HIV? Polkinghorne (2005:15) describes qualitative research as an inquiry aimed at describing and clarifying human experiences as it appears in people's lives. Considering these aspects of qualitative research, I was convinced that a qualitative approach was most appropriate for this study. I became concerned with meanings, which the participants attributed their experiences of being HIV positive and to what they considered to be their spiritual problems and needs.

⁴³ Denzin and Lincoln (1994:3-4)

Creswell (2007:11-13) is of the opinion that the gift of qualitative research in practical theology is that it encourages attentiveness to people's faith and to integrate resources of the people's faith and bring them into conversations with challenges of everyday life. I found this argument persuasive and convincing for me to make this research a qualitatively oriented practical theological research journey. It allowed me as the researcher to pay attention to the participants' faith as their spirituality emerged as a primary resource, which could be used in conversations with their daily life challenges of living with HIV and AIDS. On the other hand, I opted for a qualitative methodology as it allows for the use of multiple methods and strategies in research⁴⁴. With this in mind, I chose to do participatory action research through the therapeutic lens of the narrative approach.

1.12.1.1 Participatory action research

Knowing that qualitative research is broad, I preferred participatory action research with people living with HIV and AIDS for its values that "all people have the capacity to think and work together for a better life"⁴⁵. In addition, Reason and Bradbury (2001:2) state that PAR considers itself to be a radical alternative to mainstream research and its objective being to transcend the distinctions between activism and research, common sense understanding and academic expertise. The objective of using PAR was to produce knowledge and action, directly useful to people living with HIV and AIDS in their quest to find healing. Denzin and Lincoln (2008:885) describe participatory action research as a research approach that consists of the maximum participation of stakeholders, those whose lives are affected by the problem under study in a systematic collection and analysis of data for the purpose of taking action and making change. It involves a high degree of cooperation between researcher and participants.

In addition, Hall (1993: xvii) describes PAR as being democratic, equitable, liberating and life enhancing. Hall adds that in this regard, stakeholders act as both participants and co-researchers and this became the position held by the people living with HIV and AIDS who participated in this research journey. The other objective of using PAR was to empower the people living with HIV and AIDS to have a voice about their spiritual care needs through the process of

⁴⁴ Creswell (2007:11-13).

⁴⁵ Smith (1996:177).

constructing and using their own knowledge. Hence throughout the research, the people living with HIV and AIDS who participated in the study were referred to as participants or co-researchers and were valued as such. This is in line with what Gaventa (1993:34) says about participatory action research that it attempts to breakdown the distinction between the researcher and researched, the subjects and objects of knowledge production by the participation of the people for themselves in the process of gaining and creating knowledge. Control of ownership of the research process and research findings is shared among all participants and this is two sided which means the researcher needs to let go of control and the participants need to step up and become more engaged.

Reason and Bradbury (2001:2) point out that the primary purpose of action research is to produce practical knowledge that is useful to people in the everyday conduct of their lives. Reason and Bradbury (2001:2) add that it is also about “creating new forms of understanding, since action without reflection and understanding is blind just as theory without action is meaningless” and the participatory nature of action research “makes it only possible with, for and by persons and communities ideally involving all stakeholders both in the questioning and sense making that informs the research and in the action, what is its focus.”

On the other hand McTaggart (1997:7) adds that participation action research is political because it is about people changing themselves and their circumstances and about informing this change as it happens. Yeich and Levine (1992: 1899) add that PAR emphasizes ‘mobilizing oppressed people to create societal level change.’ Hence defining their own reality heightens consciousness and participants may then begin to challenge expert or dominant ideas and empowerment is fostered. In this regard, Reason and Bradbury (2001:2) add that PAR is reminiscent of liberation theology in the way that it addresses issues of power and powerlessness and it views itself as a more holistic, pluralist and egalitarian approach to research, based upon the active involvement of participants rather than the exploitation of research subjects. The participants through the research stated that their spiritual need was spiritual healing and wished that their spiritual well-being be considered in their health care as part of a holistic approach to their care. In PAR, McTaggart (1997:29) says that people are actually conducting the research for themselves and reflecting on its nature. This resonates with the ideas of Smith (1996:173) when he said in PAR a

group of people collectively enters into a living process examining their reality by asking penetrating questions, mulling over assumptions related to their everyday problems and circumstances, deliberating alternatives for change and taking meaningful actions. These reflections in this research journey helped in the development of alternative narratives and strengthened the capacity of participants to voice change in the care of people living with HIV and AIDS. The participants took a transformative action which contributed to co-creating spiritual care which is relevant to people living with HIV and AIDS within the primary health care delivery system in Zimbabwe.

Nelson et al (1998:888) posit that participatory action research is premised on the belief that linking research to action is crucial as action is carried out in equal participation. Action is collectively construed just as research. Action in this regard is intrinsically tied to research because activism without analysis is counterproductive and potentially detrimental. In addition, McTaggart (1996:248) adds that as action research it is not a method, but a series of commitments to practice in this way. On the same not Smith (1997:173) describes PAR as a critical and spiritual form of research which is interested in achieving communities characterized by justice, freedom and ecological balance. On the other hand, there must be benefits for the participants and acknowledgement of their “feelings, beliefs and personal experiences” (Smith1997:183-184). Smith ((1997:187) further describes the action reflection model of PAR as “thoughtful reflection on reality and the focus is on possibilities for change.

In doing this research, I acknowledged that I was not a passive participant. I provided pastoral care to the people living with HIV and AIDS, as I am a clinical pastoral caregiver. The participants analyzed my own judgments, reactions and impressions about what was going on. This is in line with the ethic of participatory care, which is “caring with people” as indicated by Kotze and Kotze (2001:7). In other words, they did not depend on me but co-created care together as the care receivers and myself as the caregiver. This is in line with social constructionism discourse, when Hoffman (1995:117) says “only through the ongoing conversation with intimacy does the individual develop a sense of identity or an inner voice.” In the same vein, Nelson et al (1998:888) add that one of the goals of PAR is to understand and magnify how participants’ perceptions and realities are constructed and how such constructions

can build and change social interventions and rather than focusing on replication, learning should be maximized through a focus on innovation. All this involves a willingness and commitment to learning as we go. Kotze (2002:6) says of this participatory consciousness, “it is an ethical-political process”. Ethical in that the participants began to experience the power of being heard, acknowledged and respected. Kotze (2002:29) adds that participatory ethicizing means that we co-create the understandings, realities and decisions we make and with an approach like this, the unconventional terms participants/co-researchers are used in this research instead of subjects. In this understanding, I took McTaggart (1996:248) assertion that PAR as action research, is not a method, but a series of commitments to practice and I had to choose a research method which suited these commitments to practice research. Hence I chose to do PAR through the lens of the narrative approach as a method in this research mainly because of the mutual relationship between PAR and narrative research.

1.12.1.1.1 Cross pollinating narrative research and participating action research

In this research journey, narrative research was partnered with PAR in an attempt to address the research question fully using a natural pairing of two philosophy congruent practices as suggested by Sax (2006:4). Sax states that a natural kinship exists between narrative research and PAR, a pragmatic and productive research model which has been inadequately represented in research literature. Both PAR and narrative research are both influenced by notions of the “linguistics” and “interpretative turns” that have emerged in philosophy, psychology and social science. Embedded in these two research models are the ideas that knowledge is inherently constructed through language rather than corresponding to an objective reality and it is sustained through communal discursive practices. Accordingly interpretive acts not only give meaning to people’s experiences of life but these meanings have real effects on future acting in the world. Linton and Mowat (2006:35) add that all forms of qualitative research are narrative focused and participatory. The researcher listens to people’s stories endeavoring to understand the meanings they ascribe to their world and their experiences. Linton and Mowat (2006:35) add that in all qualitative data collection methods, such as interviews, focus groups, participatory observation, the researcher participates in the process of retelling people’s stories and interpreting them. The researcher is involved with the research process not as a distant observer but as an active

participant and co-researcher of the interpretive experience. In line with this argument, I became part of that which I wanted to offer.

I chose specific practices of narrative approach to guide conversations during the research process. By incorporating specific narrative practices into PAR research design, I hoped to bring more specificity to the interviewing skills as an action researcher.

1.12.1.2 Narrative Approach: A turn in research

Gerger and Quinny (2005:23) discuss the turn towards narrative approaches in research in the postmodern era by sociologists as a reaction to positivism as they noted that quantitative approaches to research were far removed from people's lived experiences and they started realizing the value of personal narratives. In this regard, Clandinin (2007:45) adds that the relationship between the researcher and the researched had to change since the focus of the narrative strain as one of human commitment, subjectivity and intention. Rabinow and Sullivan (1979:12) describe this turn in research as having the following characteristics which I considered relevant in addressing the research question: a focus on human agency as opposed to determinism, a theme of human complexity and variety as opposed to simplicity, and an emphasis on the role of context and world in human activity and especially in the human interpretation of such activity. The participants as experts of their own lives became the focus in this research journey with the understanding of the complexity of human uniqueness as expressed in the narratives they shared during the research journey. Hence this means that the other change in research was from numbers as data to language as data and the point being that when numbers are used in research, there is no way to expand the meaning of the data collected and to reveal deep understandings of human interactions.

Furthermore, Clandinin (2007:22) points out that the other turn to narrative was a move from "the general to the particular". A focus on the particular signals the researcher's understanding of a particular experience in a particular setting and involving particular people at a particular time. Hence making the particular the focus of a study signals an understanding of the value of that experience. The other turn to narrative in research by some researchers was the recognition that there are multiple ways of knowing and understanding the world. Clandinin (2007: 67) is of the

opinion that narrative researchers are able to accept and value the tentativeness and alternative views that are a result of accounts of narrative inquiry. Avdi and Georgaca (2007:407) state that in recent years, the notion of narrative has acquired increasing importance in the human and social sciences as narrative is considered a core psychological and social process as well as a concept that can help to investigate the links between experiences, meaning, social structures and culture. According to Wolgemuth (2006:1029) narrative inquiry is a qualitative research methodology, borrowing ideologically from and cutting across various literary disciplines, anthropology, humanities and the social sciences. Simultaneously it is a theory, a phenomenon and a method. Its methods involve eliciting and interpreting individual and social accounts of lived experiences. Theoretically, it aligns with social constructionist and linguistic accounts of existence: storied individuals live storied lives in narrative contexts. A narrative research presupposes knowledge to be a dialogic co-creation between participants and researcher.

Bearing in mind that theology and spiritual experience are communicated primarily within stories, this narrative emphasis can be very useful for practical theology. In this regard, Swinton and Mowat (2006:31) state that needless to say, that in all forms of spirituality, narratives have been used to emphasize a point, to force an encounter with truth and meaning. In line with this argument, the narrative approach forces us to first listen to the stories of people living with HIV and AIDS who are struggling in real life situations, not to describe a general context, but to be confronted with a specific and concrete situation (chapter three). Cole et al (2001:295) affirm that this approach to practical theology is more reflexive in its approach and method as it takes the circular movement of practice-theory-practice seriously and brings it into operation. Practical theology according to the narrative approach becomes part of doing theology and takes the social constructions within actual contexts seriously. I will elaborate on these ideas below.

1.12.1.2.1 A narrative epistemology

A narrative epistemology recognizes that stories are determined by the individual's circumstances, one's biological and cultural histories and related to the social interactions in which the stories are shared. Hence, according to Hatch (2002:11), knowledge is a human construction and the knower himself/herself constructs what is to be known. Hatch adds that it is through narratives that we present our understandings and our realities of the world as we see it.

Siles and Gale (2006:67) add that our narratives are told through our perspectives and through the other stories we tell and are constructed through the lenses of other experiences and beliefs. Furthermore, Clandinin (2007:633) stresses that the narrative captures the “temporal development of lives, the unique and histories of people and the uniqueness must be honoured.” Narrative in essence, is language.

1.12.1.2.2 Narrative theory

Narrative theory draws strongly on social constructionist approaches (1.11.2). The narrative approach links up with postmodernism (1.11.1) a body of knowledge that originated in opposition to ideas of certainty, predictability, universal truth and empirical inquiry. Both the narrative approach and postmodernism, tie in with constructionism. Hatch (2002:23) suggests that narrative inquiry falls within the boundaries of constructionism since the focus of this type of research is on constructing meanings and realities as participants tell their stories. In addition Hatch states that the researcher and the participants co-construct their realities and understandings of the stories as they engage in social meaning making discourses. The social construction of meaning and realities is based on knowledge as a social construct, language as a social phenomenon and the individual as a relational person.

The basic claims about narrative approach is authored by Moen (2006:98) as

- Human beings organize their experiences of the world into narratives
- The stories people tell depend on their past and present experiences, their values, the people to whom they are telling their stories and the context in which the stories are told.
- Narrative research realizes the multi connectedness in narratives.
- Narrative research focuses on how individuals make meaning of their lives through the stories they tell.

I elaborate on the narrative research approach in the following section.

1.12.1.2.3 Narrative research

According to Lieblich (1988:3) narrative research is used in both basic and applied research and published studies using narrative approaches are represented within all of the social sciences and medicine. Lieblich (1988:5) further illustrates that,

Because research methods should be always selected to best fit the research question, when researchers are asked by various social agencies to address real life problems to contribute their expertise to public debates or decisions, it may be advisable to approach people whose lives are relevant to the issue in an open manner, exploring their subjective inner experience on the matter at hand. Narrative methods can be considered “real world measures” that are appropriate when “real life problems” are investigated.

I agree with the above assertion and I opted to use the narrative research approach in this study because it best fits the research question as it sought to address real life problems experienced by people living with HIV and AIDS. There is a lot which has been written about the needs of people living with HIV and AIDS but very little literature is based on the experiences of people living with HIV and AIDS relating what their spiritual problems and needs are and where they are valued as the experts of their own lives. In most cases, it has been others constructing meaning and realities for others. Hence by choosing the narrative approach I wanted to correct this abnormally. I wanted the people living with HIV and AIDS to voice their own experiences, spiritual problems and needs and to explore how those spiritual problems and needs could be addressed as part of a holistic approach to their care.

As the research study was carried out in a specific context, Sarbin's (1986:4) argument, that “only a worldview based on contextualism is sufficient to account adequately for human action” became relevant in terms of the research question and the aim of the study. The root metaphor for contextualism is the historical event and it is the basic metaphor of the story or narrative. Sarbin adds that the central element is the historical event that can only be understood when it is located in the context of time and space. Contextualism is sensitive to the particulars of time and space and considers characters in relationship to other characters and to the unfolding “plot” of the experience. Accordingly Hermans-Jansen (1995:9) states that;

The person as the story teller does not react to stimuli but is oriented to the realization of purposes and goals and is involved in a continuous process of meaning construction. It is only through a contextual window, that the thick realm of human existence can be adequately described and researched.

To emphasize the importance of the context, McAdams (1996:307) adds that;

The life story is psychosocially constructed. It is not only the creation of the, I, but is jointly authored by the culture and social interactions of the individual. Because they are socially constructed, life stories are an empirical fact e.g. (I got HIV when I was pregnant with my last baby). However the life story goes beyond empirical fact. Through the life story, we select and render episodes of the past, present and anticipated future into a meaningful and coherent narrative.

In light of the above discussion, the following definitions of narrative research were employed in this research study as they suited the research question and the aim of the study. Lieblich (1998:2) defines narrative research as referring,

to any study that uses or analyses narrative material. The data can be collected as a story (a life story) provided in an interview or a literary work or in a different manner (field notes of an anthropologist who writes up his or her observations as a narrative or in a personal letter). It can be the object of the research or a means for the study of another question. It may be used for comparison among groups to learn about a social phenomenon or historical period, or to explore a personality

Clandinin and Connelly (2000:20) emphasize the dynamic and dialogical nature of narrative research in their definition;

Narrative inquiry is a way of understanding experience. It is collaboration between researcher and participants over time in a place or series of places and in social interactions with milieus. An inquirer enters this matrix in the midst and progresses in this same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling the stories of the experiences that take up people's lives, both individual and social. Simply stated, narrative inquiry is stories lived and told.

In this research my interest was to explore what could be the link between the co-researchers' experiences of living with HIV and AIDS, the meaning they attached to that experience and how the social structures and culture were interlinked to that experience in the process of deepening the participants' own understanding of their experiences. However, the nature of the research question challenged me to consider Savin-Badin and Van Niekert's (2007:97) point that narrative research must go beyond the telling of stories since it is the "story of stories." Gubrium and Holstein (2003:68) add that active questioning as the basic tool of narrative research, is used to investigate the problem with the aim of activating the participants' stock of knowledge and bring it to bear on the discussion at hand in ways that are appropriate in the research agenda. However, Gubrium and Holstein argue that active questioning is not a sufficient method for directing participants' transformations although it is necessary in creating the telling of complex, multi perspective and information rich stories. It is insufficient in that it does not track or guide the participants' subjective transformations. Wolgemuth (2006:1028) is of the opinion that, given that narrative research aims to deconstruct the fixity of adopted subject positions and open the possibility of performing new subjectivities, how then can narrative research rightly make active questioning both an investigation and an intervention?

On the other hand, the narrative interview is also the potential site in which participants ideally yet dangerously feel safe and comfortable to tell their stories. In this regard, the narrative inquiry becomes highly interventional. Wolgemuth (2006:1037) posits that when the participants open up to the researcher in ways similar to that of a psychotherapist, revealing deeply personal information, the ethical responsibility of the researcher is called into question. An ethical dilemma presents itself. How is the researcher responsible for the changes in the participants that inevitably result from the research process? How far should the researcher go in promoting or encouraging such changes? Some recommend that the narrative researcher should have some formal clinical training. The fact that narrative research is often transformative, the researcher's role in this transformation should be carefully considered. I present this ethical dilemma to make obvious the interventional nature of narrative research which convinced me to do research and therapy together in this research process. My clinical training as a pastoral caregiver who uses narrative approach to journey with patients, qualified me to do narrative research/therapy together negotiating the externalized space of the stories told by the participants blurring the

boundaries between research and therapy. I was aware of the challenges faced by participants in the transition from research to therapy and back again hence responding sensitively and appropriately was necessary.

In this regard, the following section discusses how narrative therapy was done hand in hand with the research in an endeavor to explore its validity as a therapeutic approach which can be used to explore how the spiritual problems and needs of people living with HIV and AIDS could be addressed. I found it as my ethical responsibility to the participants to do therapy together as we did the research. My ethical considerations were guided by the question, ‘who is benefitting in this research?’

1.12.1.3 Narrative therapy: An overview

Narrative therapy is a form of psychotherapy pioneered in Australia and New Zealand in the 1980s that emphasizes the importance of story and language in the development and expression of interpersonal and intrapersonal problems⁴⁶. McLeod (2009:333) notes that narrative therapy being philosophically grounded represents an alternative to the pragmatic, empiricist, instrumental therapies that have come to dominate the global psychotherapies in recent years. Besley (2001:72) points out that narrative therapy was initially developed for family therapy, however its promise of providing a way of addressing power and ethical issues through harnessing the metaphor of narrative saw it being applied in other areas. It is for this same reason that I have opted to use narrative approach in this research. Lysaght (2009:35) adds that from a narrative perspective we live our lives by the stories we tell. They fashion our lives providing structure for our day to day existence and they have the potential to propel us into a future that is shaped by our lived experiences of them. The names most commonly associated with the narrative therapy are Michael White and David Epston and my work has been greatly influenced by them⁴⁷. Currently narrative therapy has a sizable international following.

⁴⁶Weingarten (1998:37)

⁴⁷ One hotbed of narrative therapy is the Dulwich Centre in Adelaide Australia and their website is www.dulwichcentre.com.au/index.htm

1.12.1.3.1 Basic philosophy of narrative therapy

Grechen 1985, Payne 2000, White 1995, 1997 and 2000 agree that the narrative can be considered to be postmodern, post structuralism form of therapy positioned within the social constructionist domain as expressed through the work of French philosophers Michael Foucault and Jacques Derrida. Apart from these, other social scientists have informed the development of narrative therapy ideas and practices such as Edward Bruner⁴⁸, psychologist Jerome Bruner⁴⁹, social constructionist, Kenneth Gergen (White 2004:75), anthropologists, Barbara Meyerhof (White and Epston 2007: 136-139) and Clyford Geertz (White and Epston 1990:3) and sociologist Erving Goffman⁵⁰. As pointed earlier, narrative therapy is rooted in social constructionist philosophy which believes that there is no objective social reality, instead the way we view ourselves, others and the entire social world in which we live is constructed by social processes and most significantly through our interactions with others.

An important aspect of the narrative therapy philosophy is the analysis of social power which is rooted in the idea of the French philosopher Foucault (White and Epston 1990). In this view, power is seen as determining the truths by which society operates, which individuals create about their lives. This idea agrees with the feminist philosophy as both approaches are considered political stances as much as they are ways of helping and this is summed up by the maxim “the personal is political.” Power and knowledge are inseparable. White and Epston (1990:29) tell us that,

If we accept that power and knowledge are inseparable that a domain of knowledge is a domain of power and a domain of power is a domain of knowledge and if we accept that we are simultaneously undergoing the effects of power and exercising power over others then we are unable to take a benign view of our own practices. Nor are we able simply to assume that our practices are primarily determined by our motives or that we can avoid all participation in the field of power/knowledge through an examination of such motives

⁴⁸ White and Epston (1990:12)

⁴⁹ White and Epston (1990:77-79)

⁵⁰ White and Epston (1990:15)

Therapy is part of the domains of power/knowledge hence it is possible for it to become a form of social control. If we can accept this stance, then a critical evaluation of our actions as therapists in terms of power is in order. Narrative therapy often supports and encourages clients to question the dominant stories of their cultures. The narrative therapist is aware that therapy is a form of social/political action. Therefore there is a distinct sense of social activism in this approach aptly captured by Doan (1998:219), “narrative therapy concerns itself with the deliverance of clients from the weight of oppressive and totalizing stories via liberating the clients’ voices and preferences.” Therefore, narrative therapists approach clients from that position which emphasizes health and strengths. Here is a bit of White’s (1993:54) writing to give a flavor of his position on therapy and politics.

In therapy, I have participated with persons in challenging various practices of power, including those that relate to (a) the technologies of the self- the subjugation of the self through the discipline of bodies, soul, thoughts and conduct according to specified ways of being. (b) the technologies of power- the subjugation of others through techniques such as isolation and surveillance and through perceptual evaluation and comparison.

My decision to use narrative therapy in this research was also influenced by the fact that I was going to work with Shona Zimbabweans and being a Shona Zimbabwean myself was important as my ethnicity became a point of reference in the research journey. I approached the participants with the knowledge of my own background and my awareness that historical and cultural influences affect the lives of the participants. Hence I was particularly attentive and sensitive to the power differential that is inherent in the therapeutic relationship, traditional views of illness and cultural discourses that affect people living with HIV and AIDS in Zimbabwe. The narrative therapy is also guided by the notion that we are in this together⁵¹, which is something that I did in this research with people living with HIV and AIDS. By making use of narrative as guiding metaphor, I created space for new knowledge, which evolved from the story told so that the story teller and listener were involved in the construction of new meaning and understanding within the HIV and AIDS context. I was considerate of the fact that people living with HIV and AIDS

⁵¹Morgan (2000:2)

were struggling to create meaning out of their various life events in their experiences of being HIV positive.

Hence I guessed that in listening to their accounts of being HIV positive, I would understand their perspectives and how they make sense of the current situation. I was also aware of the character of my involvement with the participants which was formed not from a position of power or from an attitude of knowing but from being receptively open minded and teachable⁵². Griffith and Griffith (2002:48) assert that “what it means is that we choose for a particular move of working in our own involvement with others that afford the space for enlarging inquisition, openness and amazement as our dominant emotions.” This became my position throughout the research journey.

1.12.1.3.2 Theory of the person and development in narrative therapy

Narrative therapy does not have much use for a general theory of development of individuals but more interested in the client’s unique trajectory through life, cultural context and personal understanding of the current situation. Zimmerman and Dickerson (2001:419) suggest that we are all multistoried and how we believe in a given situation depends upon which story has the most influence at that point in time. Hence narrative therapists see humans as having multiselves, but the expressions of these are situationally determined.

I recognized that the participants in this research were generally in the sexually active age group and married except for one who was a widow, but I didn’t make any assumptions about what this experience meant to them. What I observed was that the participants struggled to define who they were as individuals. After listening to their stories, I understood that at that time, for the participants, ‘self’ was described as being HIV positive.

1.12.1.3.3 Overview of the therapeutic atmosphere

In narrative therapy “ensuring an atmosphere of curiosity, respect and transparency is the responsibility of the therapist” (Morgan 2000:300). I tried to do this throughout the research journey. My role in this regard was to ensure that, a conducive atmosphere prevailed throughout

⁵² Freedman and Combs (1996:44)

the research process. I always checked with the participants to see if it was ok to proceed and also to see if I understood what was said accurately and if the conversation was on the right track. I intentionally refrained from any form of questioning or conversations which would possibly turn the participants into objects of research. I intentionally refrained from questions that sought objective information rather than experience I conducted many group and individual conversations with the participants in a fashion that promoted the social constructionist character of the research. Van Deventer (2002:6) writes about the importance of such conversational interviews as follow,

In this way the social constructionist character of a research takes shape from the outset while conducting free ranging and in depth conversational interviews with individuals and groups will further enhance the narrative nature of the research.

1.12.1.3.4 The position of the researcher

The position of the researcher in narrative research is critical in the process of gathering data. As indicated by Ressman (2008:89), my position was not to find narratives but instead to participate in the creation of the stories. The significance of the narrative metaphor in this research amongst others presupposes that stories are determined by the context, are multi-cultured in nature with dominant and alternative descriptions and that the narrator is the best guide of an own story. Hence due to my knowledge and experience as a pastoral caregiver, I had the responsibility to deconstruct my power and position in order to enable participants to become the primary authors of this research story. In this regard, I used accountability transparency and feedback practices to deconstruct my power. I was committed to a bottom up accountability⁵³ which helped me to deconstruct my power. For example, I would consult the participating people living with HIV and AIDS during sessions about how the conversation was going for them, about how they saw the direction fitting or not fitting with the overall research and their preferences, about how it is affecting them emotionally and otherwise⁵⁴. I sought permission throughout the research journey to ask sensitive questions, being accountable to them all the times and acknowledging their expertise regarding their stories.

⁵³ White (1997:202-204)

⁵⁴ White (1995:169).

I adopted the dialogical position throughout the research and therapeutic conversations took place. Therapeutic conversations and therapeutic gatherings are an ‘in there’ together process, where people talk with one another and not ‘to’ one another. Together with the participants we co-created, co-researched and co-constructed new meanings, new realities, new options and possibilities and new identities. My position was always one of ethical curiosity (Botha 2006:63). I did this by asking questions in a tentative, curious and respectful way, which opened space for new meanings of spiritual healing to emerge.

Transparent practice provided a challenge to the commonly accepted idea that for therapy to have desired effects its working need to be a secret and the idea that if persons know what the counselor is up to then it will not work⁵⁵. We negotiated our meeting times, the process and confidentiality for the shared stories⁵⁶. The participants had access to the conversations notes. I tried to transcribe the participant’s stories and the conversations during the sessions and translate the participants’ words as accurately and ethically as possible from Shona into English. I also verified my transcriptions and translations with the participants and invited them to make appropriate amendments or corrections to details. I also created space and opportunities within the conversations to ask questions and make comments. I asked for consent to give the texts to my supervisor and share the comments with them.

Feedback from the participants enabled me to know what sort of therapeutic intervention is helpful and what is not. The feedback that came from this evaluation helped me to face squarely the moral and ethical implications of my practices as well as avoiding reproducing the “gaze” on participants. After the story telling I asked members of the group to say what touched them in the story giving the participants the opportunity to reflect on what had been said. They became witnesses to each other’s stories.

1.12.1.3.5 Roles of the participants

The participants as experts of their own lives became the focus in this research journey with the understanding of the complexity of human uniqueness as expressed in the narratives they shared during the research journey. By listening to the one who was telling her/his story, the participants

⁵⁵ White (1991:38).

⁵⁶Reinharz (1992:258).

then created a community of care. The way we witnessed to the stories of pain and suffering of each participating person living with HIV and AIDS was central to doing pastoral care. This is “frequently the genesis of healing⁵⁷.” I viewed the participants and myself the pastoral caregiver as partners. The partnership we had reminded me of Polkinghome’s (2004:56) comment that, “the point of the client and therapist as partners, is that therapy is a specialized discursive interpersonal activity rather than a subject knower seeking to comprehend a client as an at-a-distance object.” The collaborative nature of the therapeutic relationship leads to a therapeutic process that proceeds at the pace of the client. In many therapies, people are not positioned as experts of their own lives; therapists are (Payne 2000:212). In narrative therapy, the professional’s role is more productive and ethical as a facilitator of the therapeutic endeavor as supported by White (1995:168),

An ethical commitment to bring forth the extent to which therapy is a two-way process and to try to find ways of identifying, acknowledging and articulating the extent to which the therapeutic interactions are actually shaping of the work itself and also shaping of my life more generally in positive ways.

Therefore, I worked with the research participants as co-researchers and co-creators who were the experts of their own lives. Hence a commitment to confront my power position as the researcher fulfilling an academic role became a challenge. In this regard, I took McTaggart’s (1997:3) advice that in order to challenge this academic role in pursuit of equal participation, “considerable energy must be directed at ensuring reciprocity and symmetry or relations in the participatory action group and maintain community control of the project.” The aim of research in PAR, through collaborating and sharing participants’ diverse knowledge and experience, seeks to change the personal dynamics of the research situation so that it is co-operative and enhances the lives of all those who participate. Hence clear communication and a conscious de-emphasis on professional jargon are important. Dialoguing becomes a distinguishing feature of PAR in which people write and speak in a full voice. As Stringer (1996:160) has stated, PAR can be characterized as “the search for understanding in the company of friends.” These supportive

⁵⁷Wright, Walson and Bell (1996:161).

working relationships enable people to share honestly which includes respectful disagreement and discussion

1.12.1.3.6 Assessment

Narrative therapists do not use any formal assessment. The assumptions behind such systems are generally inconsistent with narratives therapy philosophy. However assessment in narrative therapy is seen as a continuous process that is focused on understanding client's perspectives on their lives (Smith 1997:29). Particular attention is paid to the cultural and other contexts of the clients' experiences. Multiple perspectives are honored such that, "the initial focus of therapy is on trying to grasp the local meanings and understandings of everyone involved" (Smith 1997:29). A thorough exploration of the problem is critical in narrative therapy. Morgan (2000:25) recommends researching the problem's tricks, intentions, plans, motives, deceits and lies among other things. Discussing the problem in these ways helps to externalize the problem. This shall be elaborated below in (1.12.1.3.11.4).

1.12.1.3.7 Language

Besley (2001:82) states that narrative therapy pays particular attention to language because it can blur, alter or distort experience as we tell our stories. It can condition how we think, feel and act and can be used purposefully as a therapeutic talk. The language used in narrative therapy is deliberately non-sexist, ethically neutral and avoids medical model terms that many health professionals use that unthinkingly objectify and pathologies people. The client's language is used or privileged rather than the therapist's. A narrative is language. According to Freedman and Combs (2002:194) postmodernists focus on how the language we use constitutes our world and beliefs. The only worlds that we can know are the worlds we describe to each other in language and description is an active process. There is no ultimate, universal external image of how people living with HIV and AIDS must experience their pain. The world we experience is inextricably connected to language and there is no world apart from language. In this research we realized that language is seen not just as a tool for communication or reflecting back reality but as an important formative part of that reality. The way we speak and write are held to influence

our conceptual boundaries and to create areas of silence as language organizes meaning in terms of pre established categories⁵⁸.

Language used in this research journey was agreed upon by the participants. As we were both Shona speakers we agreed to use Shona in all our conversations and storytelling although I had to do the translation myself. I shared with the participants all the translations which I did. We found it very liberating as we spoke and heard in our own mother tongue. In using Shona in our conversations and in their story telling the participants were able to bring forth rich descriptions of their experiences. The significance of the narrative metaphor in this research amongst others presupposes that stories are determined by the context, are multi-cultured in nature with dominant and alternative descriptions and that the narrator is the best guide of an own story. Hence language used becomes very important to achieve this. As I reflected on this issue, I realized that the language used was more life enhancing, self-affirming and positive in outlook. To some extent I want to emphasize that using the right and desirable language during communication with people living with HIV and AIDS can help to alienate the burden of living with the disease. Although there is no Shona word for HIV and AIDS the participants referred to it as the sickness (*chirwere*) or disease and throughout the discussions culturally familiar metaphors were used for all the terms which are considered embarrassing by the Shona people especially when talking about sex. Language is the medium through which we socially construct, deconstruct or re-construct reality. Because of the complexities of the participants' experiences, a postmodern view of language was very useful as it acknowledges that the only worlds we know, we share in language and language is an interactive process. Not a passive one. Therefore the language used in the research journey was accessible and inclusive and did not leave out the participants with a sense of inferiority about themselves.

1.12.1.3.8 Goals of narrative therapy

Shapiro (2002:99) states that the overarching goal of narrative therapy is to help the patient replace the problem-saturated story by reconstructing a preferred story based on the unique outcomes. The building blocks for this new story are found in the discovery of hopeful moments,

⁵⁸ Lather (1992:95) asserts that language is seen as both carrier and creator of a culture's epistemological codes.

thoughts, or events that do not fit with the problem story. Shapiro (2002:99) adds that “patients are often dismissive of these sometimes small and initially uncharacteristic glimmers.” The pastoral caregiver can play an important role by questioning this perception.

In the research journey, the problem-saturated stories were deconstructed using various narrative techniques explained below and reported in Chapter four. The problem as identified by the participants was spiritual pain which they experienced in their spirits from the impact of HIV on their lives. For the participants to further understand the spiritual problem, deconstructive questions were used to enable the participants to relate how the spiritual pain manifests in their lives. The spiritual need of the participants was spiritual healing which meant different understandings among the participants but converged on God being the healer of the spiritual pain. This became the unique outcome on which the alternative stories began to be reconstructed. These are reported in Chapter Five.

1.12.1.3.9 Data collection and data analysis

The research was participatory action research and a narrative inquiry approach was employed to gather the data for this study and narrative is the form of the data collected. In this regard, data analysis occurred as data was being collected. Memann (1998:162) states that the right way to analyze data in qualitative research is to do it simultaneously with data collection otherwise the data retrieved can be unfocussed, repetitious and overwhelming. Data collection was done through storytelling by the participants, dialogues, group discussions and in-depth interviewing which involved repeated conversations with the participants that focused on their perceptions of self, life and experiences as expressed in their own words. The conversations were not highly structured but open to be steered by the participants. Shapiro (2002:99) adds that a narrative approach does not involve persuasion or coercion; rather, it encourages the patient to find his/her own voice and to make choices about how he/she wants to live. Shapiro adds that patient’s viewpoint is not opposed as this may result in the escalation of defensiveness and resistance.

Therefore the data analysis was viewed as a collaborative effort between the researcher and the participants hence it represents the voices, views and interpretations of the participants. Data analysis was done by generating themes with the participants which led to new ways of seeing

and understanding problems and needs as well as new ways of preferred living which developed into alternative stories. In this regard, the common themes and issues identified were brought back together into meaningful relation with each other, developing as it were, a narrative of the core elements of the experiences described by the people living with HIV and AIDS. The participant's own perspectives or subjective experiences of their worlds are reflected in this research report in the participants' own words. Recording participants' exact words contributed to thicker descriptions of the details of their lives. The participants were engaged in the interpretative process. They gave feedback on my reflections. The participants also reflected on what the participants also said or on the story told as a reflecting team.

The participants who took part in this study were expected to attend two individual and two group sessions of about two hours each per week for six months. After each session they received a summary of the session. They were asked to make comments, corrections and/or provide feedback regarding the summary. Although the sessions were in Shona, this report is in English. Therefore all the summaries as well as other correspondence were in English. At their request those were translated into Shona. No financial reward or any form of payment was made for participation in this study. The participants were allowed to withdraw from the research project at anytime without any consequences to them.

Based on the narrative approach, I listened to the stories of people living with HIV and AIDS in order to gain an understanding of the in-context experience. My interest was not to look for data but for meaning and interpretations given by the co-researchers. I listened for clues in the people's narratives about their experiences of God. This was not a forced effort by the researcher to bring God into the present situation, it was an honest undertaking in order to hear and understand the co-researchers' spiritual understanding and experiences of God's presence⁵⁹. I would further invite the co-researchers to engage in the creation of new meaning or the development of alternative interpretations which meant deconstruction and emancipation that pointed beyond the local context. Muller (2005:11) adds that such a bold move should be taken to allow all the different stories of the research to develop into a new story which contributed towards co-creating a spiritual and pastoral approach to healing of people living with HIV and

⁵⁹ Muller (2005:11)

AIDS which is contextual and having possibilities for broader application. During the interviews, I did not use tape recording as the participants did not want to be recorded. I took notes to keep record of the information. Confidentiality and safe keeping of participants' records and narratives was maximized and maintained throughout the study.

Due to the extensiveness of the research, all the stories and conversations that were listened to, as well as the verbatim reports, could not all be recorded in this dissertation. The research findings recorded a 'collage' of the 'story-parts'. These 'parts' will hopefully become the sum of the total world story of those infected by HIV. However, I admit a bias in the selection of the 'story-parts'. The stories recorded in this study are therefore part of the story and not the story in itself. The stories and story-parts provided here are efforts to make known to a wider audience the spiritual pain, suffering, the quest for spiritual healing people living with HIV and AIDS experienced and are experiencing. Myerhost (1982:110) states that a story told aloud to others is of course more than a text. It is an event when it is done properly, its effects on the listener is profound and the latter is more than a mere passive receiver or validator. The listener is changed and I vouch to this, my life after this research will never be the same again. My commitment to people living with HIV and AIDS will be more and my perspective on my personal life has been impacted by this work.

Having co-researchers in this research, challenged me to present this research report in an accessible and inclusive language that does not leave the participants marginalized with a sense of inferiority about themselves⁶⁰. Therefore I had to let go of my technical theoretical language and use everyday language that invites everybody's participation. The next section discusses the various narrative constructs and therapeutic technique/practices which were used to research the problem in a therapeutic way that led to the re-authoring of alternative stories.

1.12.1.3.10 Central constructs in narrative therapy

The significance of the narrative metaphor in this research amongst others presupposes that stories are determined by the context, are multi-cultured in nature with dominant and alternative

⁶⁰ Kotze (2002:28).

descriptions and that the narrator is the best guide of an own story⁶¹. Human life, according to the narrative therapy tradition, is a series of stories which are created over time through our attempts to connect events in our experiences and in this way derive meaning from them⁶². Morgan (2009:5) writes that, “for narrative therapists, stories consist of events linked in sequence across time according to plot.” However, some events become privileged over other events and are included in what becomes the dominant story for the individual (Morgan 2000:7). The dominant story is referred to as the problem saturated story at that time and this story is what prompts people to seek therapy. In contrast to the dominant or problem saturated stories are alternative stories and these are often important in helping clients. Alternative stories are usually hidden by the dominant problem saturate stories. We all live complex lives that invariably there are aspects of our experiences that do not get included in the problem saturated stories. Dominant stories are usually rich and thick in description whereas the alternative stories tend to be sparse and thin. Problem saturated stories have also very restricted views of the person and do not include details about the strengths or competences of the individual.

1.12.1.3.10.1 Problem saturated stories

According to Lysaght (2009:35) stories can be expressed in a variety of different ways they may involve oral or written accounts of experiences or they may exist in visual form. Lysaght explains that regardless of the medium however the story resides in a space that is external to the teller of the tale and accessible to interpretations by others. In this research journey, the participants and me became part of the externalized space for the story being told and the participants were given time to reflect on the story told. While this externalized space became a productive site for collaboration resulting in therapeutic value for the storyteller, as a researcher involved in narrative inquiry I also negotiated this space blurring the boundaries between research and pastoral care. I took heed of Lysaght’s (2009:35) warning that an awareness of the challenges faced by participants and the ability to respond sensitively and appropriately was necessary as the transition from research to therapy and back again occurred.

⁶¹ Griffith and Griffith (2002:83-84)

⁶² Morgan (2000:4)

The assets in the African context that were capitalized on in this research were, the ability to tell stories and many African experiences have been expressed and developed through cultural singing and dancing. My presupposition was that a storied approach to spiritual care could be developed through engaging the client in a relaxed mood of telling stories, singing and dancing. And these were a great help in assisting the participants to alienate themselves from the effects of the spiritual pain on their lives. I began by asking each participant to tell his/her story describing their experiences of being HIV positive as backdrop to understanding their spiritual problems and needs. The seven participants in the study eagerly compiled and shared their problem saturated stories (Chapter Three) describing the unimaginable pain of being HIV positive. After each story, I asked the other participants to reflect on the story told. At that time these were the dominant stories of the participants heavily situated in cultural discourses of what it means to be HIV positive in Zimbabwe. The participants had very rich and thick stories about their problems of being HIV positive that were highly connected to the dominant discourses of the Zimbabwean society. I thought these descriptions of the participants were very much influenced by power and politics and they represented very thin views of who the participants really were as people. I listened to the stories of people living with HIV and AIDS in order to gain an understanding of their in-context experience as backdrop to studying their spiritual problems and needs in order to explore how these could be addressed within the primary health care delivery system in Zimbabwe.

The storied experiences were made, described and developed in collaboration with co-researchers. My interest was not to look for data but for meaning and understandings given by the co-researchers. I listened for clues in the people's narratives about their experiences of God. Muller (2005:11) says, "this is not a forced effort by the researchers to bring God into the present situation, it is an honest undertaking in order to hear and understand the co-researchers' religious and spiritual understanding and experiences of God's presence." From the first day the co-researchers brought God into their stories through their questions. Hence God became an integral part of the conversations throughout the research. I further invited the co-researchers to engage in the creation of new meaning or the development of alternative interpretations, which mean deconstruction and emancipation that point beyond the local context. Muller (2005:11) adds that the bold move should be taken to allow all the different stories of the research to develop into a

new story. This research journey became the beginning of a new story of spiritual healing for the participants.

1.12.1.3.10.2 Unique outcomes

Unique outcomes are events that are not part of the dominant problem saturated stories. These are the exceptions to the problem's rule and are very important in helping clients escape the tyranny of the problem. As I listened to the participants' narratives, I took notice of the statements that contradicted the dominant story. These are known as unique outcomes⁶³ which are sometimes referred to as "sparkling moments"⁶⁴. I used the unique outcome as a point of entry for the reconstruction of the participants' alternative stories where the participant's spirituality emerged as a hidden resource on his/her spiritual path towards spiritual healing. The narrative therapist is very interested in unique outcomes and spends a lot of time asking detailed questions about them, getting the client to expand upon their descriptions. I saw a glimmer of hope in the participants when they stated that God is the healer of their spiritual pain. The narrative approach views problems as separate from people and assumes people have many skills, beliefs, values, commitments and abilities that will assist them to reduce the influence of problems in their lives. The participants believed that God is the healer of their spiritual pain. My own understanding of God's presence in this given situation also constituted a valuable contribution. I asked and I listened for clues in the participant's narrative about their experiences of God. All the co-researchers were invited and engaged in the creation of new meaning on the basis of a holistic understanding and social constructionist process according to the narrative approach. Together with the co-researchers a bold move was taken to allow all the different stories of the research to develop into a new story of understanding that pointed to God as the healer.

In line with contextual, postmodern and feminist theologies, the pastoral conversations, the participants' conversations with God and their relationship with God were respected. The premise was that God is greater than any understanding, experience or writing could ever describe. Therefore people's experiences with God may differ from one person to the other and from one situation to another. God is not a creation or projection of human beings and His

⁶³ Morgan (2000:50)

⁶⁴ Freedman and Combs (1996:59)

existence is by Himself and does not depend on human construction or conversations. God exists regardless of how and whether people talk or do not talk to one another about God. During these conversations about God, I also searched for any slight indications of resistance to the domination problem narratives that could be utilized to create the opportunity for an alternative story.

1.12.1.3.10.3 Re-authoring conversations: The alternative stories

In using narrative therapy, re-authoring conversations take place between a therapist and the person who seeks help and involves the identification and co-creation of alternative stories of identity. The re-authoring process involves continued invitations to persons to separate their identity from the problem, to reflect on the unique outcome and consider previously undistinguished choices. The therapeutic conversations in this study highlighted new and rediscovered understandings and previously unnoticed choices that were valued by the participants and weaved them in to the new stories emerging. Freedman and Combs (1996:42) add that in re-authoring stories we work with people in ways that invite them to celebrate their differences and to develop and perform narratives that they prefer around the particularities of their lives. By taking a postmodern stance, I hoped to allow the stories to tell themselves in line with what Epston (1998:24-25) states that a re-authoring therapy intends to assist persons to resolve problems by:

- 1) Enabling them to separate their lives and relationships from knowledges of stories that are impoverishing.
- 2) Assisting them to challenge practices of self and relationship that are subjugating and
- 3) Encouraging persons to re-author their lives according to alternative knowledges/stories and practices of self and relationships that have preferred outcomes.

I found these pointers very helpful because instead of looking at people who had spiritual problems to be resolved through my expertise, I was now being encouraged to facilitate the re-constructing of preferred stories in a way which viewed the participants as the experts of their lives. This is a paradigm shift from modernism where therapists tended to think in terms of the

help they gave as being controlling so that specific goals were reached with the therapist being viewed as the expert of people's problems.

In addition, Russel and Carey (2004:21) concur that the practice of re-authoring is based on the assumption that no one story can possibly explain the totality of a person's experience. There will always be inconsistencies and contradictions. Our identities are not single storied we are multistoried. Frank (1995: xxi) stresses that illness or suffering people are wounded not only in body but also in voice. In this way Frank (1995: x) challenges the dominant cultural conception that the ill or suffering people should be approached as a passive victim of a kind. In this research through narrative therapy, the disempowered participants, were empowered to have a voice, person to sooner turned their illness into stories, misfortune was converted into experience, the HIV and AIDS that sought to tear the body apart from others became, in the story, the common bond of suffering that joined bodies in their shared vulnerability and gave power to the re-authoring of new stories of hope. In the next section, I describe the therapeutic techniques/practices used to research the problem, birth the unique outcome and re-author the alternative stories of the participants.

1.12.1.3.11 Narrative practices used

Narrative practices are many but I discuss briefly below the main practices I found useful in this research. In the following chapters where necessary the practices are further explained in more detail with reference to how the practice was used as for information gathering as well as a therapeutic practice.

1.12.1.3.11.1 Naming the problem: A problem is a problem

Morgan (2000:2) describes narrative therapy as, "a respectful, non-blaming approach to counseling and community work which centres people as the experts of their own lives". An important maxim of narrative therapy is that, "the problem is the problem, the person is not the problem" and the experts in a problem are the people who experience that problem and propose helping people by separating the problem from the person using externalizing conversations⁶⁵. In

⁶⁵White (2007:9).

identifying a problem as a problem, the participants were enabled to name the problem as spiritual pain even though it meant different things to the participants. Spiritual pain also manifested differently in their lives. We practiced externalizing conversations throughout the research journey by using language. Although it was difficult to translate externalizing conversations and to practice them in Shona, we used Shona-English and it worked for us. Instead of saying my problem is spiritual pain, in externalizing the problem, one would say, the problem is spiritual pain. Through this narrative practice, the participants learnt to separate themselves from the problem. They learnt to look at the problem separately from themselves and this helped them to deconstruct the problem and re-construct new reality as a way of story repairing. Avdi and Georgaca (2007:407) adds that in the narrative approaches to therapy, psychological difficulties are seen to reflect on situations where one's self narratives do not sufficiently represent vital aspects of lived experiences. Therapy is conceptualized as a process of "story repair" where problematic self narratives are reconstructed to become more coherent, complex and inclusive. In this regard my role as researcher and pastoral caregiver was reconceptualised as that of a witness to the participant's story telling as well as co-editor of the unfolding narrative, which became an alternative story of healing.

1.12.1.3.11.2 Exploring the effects of the problem: Deconstruction

Furthermore, White (2000:170-171) describes narrative therapy as being, "about local inquiry into what's happening into how things are becoming other than what they were, or into the potential for things to become other than what they are'. This research was intended as an inquiry into the care of people living with HIV and AIDS within the PHC to become other than that which it is. Narrative therapy provided me with a particular deconstructive stance and with a reference for the kind of questionings that opened up that possibility. My assumption was that the social construction of HIV and AIDS in Zimbabwe is somewhat at odds with the ideology that has shaped the HIV and AIDS service delivery policy in Zimbabwe. Therefore the care and counseling of people living with HIV and AIDS is being normalized into a culture largely influenced by North American and European conceptions which usually emphasize individualism. Hence the research was done with the participants as a group most of the times

and individually at the participant's request. The benefits of the group were enormous and contributed effectively to the co-construction of spiritual care.

In narrative therapy, deconstruction is a way to exploring the effects of the problem in therapy. White (1993:34) describes deconstruction as having to do with,

procedures that subvert taken for granted realities and practices: those so called "truths that are split off from the conditions and contexts of their production; those disembodied ways of speaking that hide their biases and prejudices and those familiar practices of self and relationships that are subjugating of person's lives.

White (1993:35-39) cites three targets of this deconstruction: the narrative of the self, the practices of power in our culture that impose themselves into the stories of clients and the practices of knowledge that clients tend to expect of the experts they face. The listening and questioning by the therapist all communicate subtly or directly the social constructionist epistemology that undergirds it. White (1993:53) further explains that the often oppressive practices of power in our culture are also constructed primarily through being "unmasked" and this unmasking empowers individuals to counter the influence of these practices in their lives and relationships. As the practices of power continue to be deconstructed, the people no longer experience being at one with these practices and begins to sense certain alienation in relation to them and they become free (White (1993:54).

In the same vein, the therapist also seeks to deconstruct the practice of knowledge that is largely represented by him/her. Hence the therapist takes on the 'not knowing' stance described below and uses language very carefully because of the understanding that language contains "built in injunctions against questions that might be raised about their socio/political/historical contexts" (White (1993:56). It is largely for this reason that diagnostic and medical language is generally avoided. The most important technique for this deconstructive work is that of externalization described in (1.12.1.3.11).

1.12.4.11.3 Thickening the alternative stories: Witnessing and expanding

Weingarten (2003:22) uses both postmodern and feminist theory to propose that becoming a witness is a systemic process of meaning making, where the ability to witness depends on a

willingness to assure the risks associated with authentic connections. As a group we created witnesses to the shared stories. In narrative research witnessing refers to the context within which voice is produced⁶⁶. A voice in this regard is not an individual's achievement of self knowledge but rather a possibility that depends on the willingness of the listeners that make up the person's community⁶⁷. In this regard the participants listened to each other's stories; they became the community of witnesses who also reflected on each other's story. Hence as they took up this position they became the participating reflecting team or the outside witnesses. By witnessing to the stories of people living with HIV and AIDS in this group healing took place and this is also supported by Mattingly (1998:2) who alludes that illness narratives carry important functions beyond providing a form of talk. It also serves as an aesthetic and moral form underlying clinical action. I discovered that for the participants being listened to in this way, was like, "being thrown a life preserver in a choppy sea. The life preserver is a connection to another person and the experience of isolation and abandonment abates."⁶⁸ When the witnesses offered their reflections and resonances, conversational space was opened for the development of alternative stories and preferred identities for both speaker and witnesses. In this way both were moved into new territories of identity as they carried a different awareness of themselves than they had before.

Throughout the research journey, the participants shared and responded with open hearts to each other becoming compassionate witnesses to themselves and to each other. I realized that a healing circle was created which became a container for the pain and sadness and also for alchemy of inspiration and solace."⁶⁹ In this healing circle, the group experienced something described by White (2000:77), "that unique sense of being present to each other in entering liminal circumstances betwixt and between known worlds." Re-membering conversations (5.5.1) and outside witnessing (5.5.2) as indicated in Chapter Five became rich metaphors when we reflected on the effects of witnessing and re-authoring of alternative stories. HIV and AIDS separate people from vital aspects of themselves producing disconnection from friends, family, and local communities. This disconnection was clearly visible in the participants' narratives. To

⁶⁶ Weingarten (2000:392).

⁶⁷ Weingarten (2000:392).

⁶⁸ Weingarten (2003:199).

⁶⁹ Weingarten (2000:196)

further assist the participants to expand on the re-authoring conversations, rituals, celebrations and documents such as certificates were also incorporated (5.53). All these approaches take advantages of the power of ritual in solidifying and memorializing significant life changes⁷⁰.

1.12.1.3.11.4 Externalizing conversations

This is a linguistic practice used in narrative therapy, which assists the therapists to join with their clients in researching the problem and its effects on their lives in ways that exposes and challenges dominant cultural narrative by which people organize and live their lives⁷¹. As people provide accounts of personal experiences their stories become located in a space that is external to them as indicated by Lysaght (2009:35). This externalized space is a dynamic and powerful arena in which the events and experiences that unfold can be examined and reshaped as the individual involved separates self from the story. For the storyteller an exploration of alternative understanding can be undertaken as disruptions or oppressive experiences become available for considerations. For the group, the space that was created by a story provided access to information that could be negotiated in various ways. As a pastoral caregiver, I encouraged the participants to examine particular aspects of their experiences and as part of a planned process, explored alternative understandings with them. The externalized space could have been more difficult to negotiate if I was not prepared for its dynamic nature and the effects that stories have for the narrators as well as their audience.

In the same vein, as we negotiated the externalized space with the participants, we became aware of our own vulnerability and the tensions that we experienced as another's story unfolded. Navigation of the externalized space created by personal stories in research journeys requires a sensitive and informed approach to the needs of others. At times this meant that as the participants' stories involved us emotionally we had to be prepared to acknowledge these experiences and draw on them in order to enrich an experience we encountered. The challenge was to navigate this space in ways that were productive for both the participant and the research with which we were engaged.

⁷⁰ Shapiro (2002:99)

⁷¹ Morgan (2000:46-47)

Lysaght (2009:35) adds that the words we use do not simply reflect meaning but rather they are performative words that give shape to the meaning of experience in our lives. Bruner in Lysaght (2009:35) stresses that with each telling of a story, there is a possibility that we can become the authors of new and perhaps preferred stories for ourselves. From this perspective stories are powerful instruments valued by researchers and therapists alike for their ability to convey detailed complex and often intimate experiences whilst providing a foundation for change. This became a reality in this research journey.

1.12.1.3.11.5 Questioning: The basic tool of narrative therapy

Therapeutic questions are considered to be the basic tool of narrative therapy⁷². Narrative questioning has the intent of uncovering meaning and generating experience rather than creating information⁷³. The suggestion made by Muller (1999:22) that, these questions should make people to discover and re-discover and use their own resources in the processes of re-authoring ‘their own future stories around their own ‘pots of honey’ influenced the way I asked the questions during the course of the research journey. In addition, Freedman and Combs (1996:57) state,

Deconstructive questioning invites people to see their stories from a different perspective, to notice how they are constructed, to note their limits and to discover that there are other possible narratives.

Narrative questioning emphasizes participants making their own interpretations of events and formulating their own insights. Shapiro (2002:97) adds that the narrative questions are also used to invite people to see their stories from different perspectives and to understand how they are influenced by sociocultural factors. Shapiro adds that some of the questions ask the people to envision different, more hopeful outcomes for themselves, to probe the significance of rare but hopeful events in their lives and help them to recognize that they are constantly making choices for or against a particular problem saturated story.

⁷² Shapiro (2002:97)

⁷³ Shapiro (2002:97)

These suggestions helped me to realize that the therapeutic questions were essential as they enabled the participants to see that those limiting narratives are not inevitable and that they do not represent essential truths about their lives. Freedman and Combs (1996:113) add that questions become therapeutic in and of themselves if they are asked to generate experience of preferred realities rather than gather information and not from a position of pre-understanding. We should endeavor not to ask questions that we think we know the answers to, or ones that we want particular answers to. Therefore the questions I asked were not to interrogate the participants, or to push, manipulate them in a direction which I wanted. In this regard I realized that the way I listened was very important.

1.12.1.3.11.6 Responsive-active listening

Freedman and Combs (1996:44) point out that the importance of listening in a narrative therapeutic situation is, “as simple as it may seem, in the face of prevalent discourses and dominant knowledges, simply listening to the story someone tells us, constitutes a revolutionary act.” Freedman and Combs further explains this special kind of listening that is required in this work as “deconstructive, listening.” This enables the therapist to listen to people’s stories as they perceive them to be and not necessarily in a manner the therapist understands. Sometimes therapists think that they need or are expected to verbally respond to everything the people living with HIV and AIDS say. In this study I discovered that much of what was said by the participants did not require verbal response or even understanding, but rather empathetic listening. In order to achieve this kind of listening, Muller (1999:35) suggests that the therapist should not merely listen to the client’s story in a neutral sense but that there should rather be ‘a willingness to become involved in that story.’ In agreement, Ekerhart (1996:24) expresses some significant reflections on the art of responsive – active listening, which I also found helpful in this work as he writes, “as we listen we become aware of ourselves and begin to understand our relation to others and their relation to us.” I became involved in the participants’ stories and I became aware of myself in relation to the participants and the questions I asked expressed genuine curiosity in facilitating the participants to re-author their alternative stories based on the unique outcome identified from their problem saturated stories.

1.12.1.3.11.7 The Not-knowing Position

In narrative therapy, the therapist is a collaborator and clients are the true experts on their lives. Throughout the research journey I maintained the not –knowing position and I found the insights of Prosser (1999:1) very helpful in my understanding of my position as he points out;

An expert in the process of change, rather than an expert in the life of the client. The therapist can never know more about the client's life and needs than the client themselves. The therapist cannot know whether or what change is wanted without asking and does not presume to take a position on the rightness or otherwise of what the client wants.

This suggested to me that I had to free myself from constructing frameworks supported and perpetuated by training, themes, counseling and theory models, ethics and beliefs. This suggested a deliberate and conscious move away from a position or stance of knowing. Anderson (1997:4-7) outlines the not-knowing position as follows, which I also found useful.

- Become genuinely immersed in and inquisitive about what the client said

I became more focused on maintaining coherence within the participants' experiences and I was committed to being informed by their experiences and stories.

- Listens differently

I listened to the participants' emerging new stories as they perceived them and not necessarily in a way I understood spiritual healing and how God was going to heal them. I also listened to hear and to be involved in the creation of a new story of hope.

- Speak the client's everyday language

I spoke the client's everyday language as we were both Shona speaking. I didn't use any translators, as we understood the language in the conversations we had. We were both very comfortable with the idea of speaking the same language.

- Suspend the therapist's pre-knowledge and focus on the client's knowledge

I realized that the more I suspended my own knowledge about God being the healer of spiritual pain, the more room there was for the client's voice to be heard and their expertise to come to the fore front and be appreciated. I realized that it was in my not-knowing that I became knowledgeable.

- Move from a one way inquiry towards a mutual inquiry

Therapy became based on a two-way conversational, give and take process, crossing of ideas, opinions and questions.

- Dissolve the need for intervention

As I learnt about the language, meaning and direction as preferred by the participants, I spontaneously began to abandon my expertise on what spiritual healing is all about and how they should be healed.

- Value the sense of unpredictability/uncertainty

As I did this I had the freedom of 'not-knowing' and not having to know. This position gave me an opportunity to relax and enjoy the beginning of the participants' emerging new stories of spiritual healing based on the unique outcome 'Only God can heal.' In this regard the therapeutic questions became a very valuable tool throughout the re-authoring process.

1.12.1.3.11.8 The journey metaphor

The use of the metaphor of a journey, which is a narrative way of engaging with people was also helpful in that, it conveyed the idea of a long term process and long term relationship in which people live their stories with the intention of holding onto the narrative of time⁷⁴. The group experienced spiritual pain for a long time therefore 'quick fixes' did not work for them and they needed to find the skills they needed to live with the spiritual pain on their life's journey rather than try to eliminate it from their bigger stories. Their experiences in the past were that many people had tried to help them (traditional healers, faith healers, prophets or church pastors) and

⁷⁴Morgan (2000:3)

other people but nothing helped in terms of the spiritual pain they experienced. But on this journey they experienced glimpses of spiritual healing despite the fact that spiritual pain is still there.

1.12.1.3.11.9 Reflexivity as reflection

Willig (2001:10) is of the opinion that reflexivity urges researchers to explore the ways in which their involvement with a particular study influences, acts upon and informs such research. It requires an awareness of the researchers' contribution to the construction of meaning throughout the research process and an acknowledgement of the impossibility of remaining outside of one's subject matter while conducting the research. There are two types of reflexivity, personal and epistemological reflection. Personal reflexivity involves reflecting upon the ways in which own values, experiences, interests, beliefs, political commitment, wider aims in life and social identities have shaped the research. It also involves thinking about how the research may have affected and possibly changed us as people and as researchers. Personal reflection can therefore be argued, occurs as a response to questions the researcher asks him/herself.

Willig (2001:10) describes epistemological reflexivity as involving us to engage with the research question such as how has the research question define and limited what can be found? How has the research design of the study and the method of analysis constructed the data and the findings? It encourages us to reflect upon the assumptions that we have made in the course of the research and it help us to think about the implications of such assumptions for the research and its findings. In this study both personal and epistemological reflections were done throughout the research process but it was further elaborated and consolidated in chapter six.

1.12.1.3.11.9.1 Reflecting teams

Cole et al (2001:5) state that in narrative therapy, the notion of reflecting is defined as thinking seriously or contemplating on or upon something and reflecting in this regard is viewed as an opportunity to offer new and multiple perspectives to clients where voices can be heard. Ideas can be generated and new perspectives can be offered. Group members take turns to share positive comments about what the other client has said. The group members in this regard become the reflecting team. The comments made by the reflecting team should be "appropriately

unusual in the sense that the remarks should be different enough for clients to hear something new but not too different for the clients to identify with the team's messages" (Cole et al (2001:5-6). During the research process, each participant was given a chance to share their story and at the end of each story I would invite the other participants to make comments about the story as a reflecting team (chapter three).

1.13. Pilot study

A pilot study was not used for this research. I understand that pilot studies inform the novice researcher about what the study will entail but for narrative inquiry, each narrative is unique and cannot be known, predicted or prepared for in advance⁷⁵. In other words, the same results will not be achieved each time unlike in quantitative studies which aim to yield the same results each time thus achieving a valid or reliable method. The stories of the people living with HIV and AIDS were created within the context of the group conversations. A Polkinghorne (2005:6) point out that narrative research is conducted in order for the researcher to say something to readers about the human condition. In this regard storied evidence is gathered about the meanings, experienced by the people whether or not the events are accurately described and this cannot be prepared in advance. Gubrium and Holstein (2003:73) describe active questioning in narrative research as a way to provide an environment conducive to the production of a range and complexity of meanings that address relevant issues and cannot be confined by a predetermined agenda. In addition, narrative research is not about asking questions to elicit the participant's truth, but to socially construct knowledge where the active participants become the productive source of knowledge⁷⁶. In this regard, narrative inquiry often presupposes knowledge to be a dialogue co-creation between participants and researcher. Furthermore, stories and those who tell them are situational and temporal. Narrative accounts therefore can and often do change across contexts and with time. Given the intersubjective nature and the transformational potential of creating narrative accounts, carrying a pilot study in this regard was deemed unnecessary.

However there was need to create the space for the telling of complex multiperspectival and information rich stories with the participants' full array of knowledge resources. My desire

⁷⁵ Chase (2005:602)

⁷⁶ Gubrium and Holstein (2003:74)

throughout the study was to understand the participants' spiritual needs and problems rather than control and predict them since according to narrative research there are various ways of knowing and various ways of questioning what knowledge is and how it is constructed⁷⁷. Therefore my position throughout the research was that of not knowing. It is my goal that in sharing the narratives of people living with HIV and AIDS who became participants in this research, I do so by engaging the readers in the lives and experiences of the people and as well as engaging readers in a dialogue with the text as they read.

1.14 Research site

The research study was conducted in the Midlands Province of Zimbabwe at Gweru Provincial Hospital. Gweru Provincial Hospital is a public health institution which falls under the Ministry of Health and Child Welfare. According to the MOHCW (2010) report, the hospital serves as a referral hospital for the Midlands Province's eight district hospitals and caters for patients who are referred from the clinics in the rural areas as well as from townships. The district hospitals usually refer patients for further management and specialist/complicated cases and services. The same MOHCW report, state that the hospital is also a multi-disciplinary training institution that offers registered general nursing, midwifery and environmental health technician training. The hospital has an Opportunistic Infectious Clinic (OI) which caters for HIV and AIDS patients. MOHCW report states that the hospital serves the fifth largest population in the country and about 2000 HIV and AIDS patients receive their ARVs from the provincial hospital. It is situated 1,6 kilometres from the central business district along Shurugwi road. The hospital is right at the central nerve centre of the road network of the country, which is on the Harare-Beitbridge, Harare-Bulawayo.

Gaining access into the research site was not a problem for me as I grew up and worked in Gweru for many years. I currently live in Gweru and I speak the Shona language as my first language which most of the people in Gweru speak. Knowledge of the culture of the people concerned also helped me as I had to display how I value their culture making the participants feel comfortable to disclose their personal experiences of being HIV positive amid a highly conservative and stigmatizing society. At the Gweru Provincial Hospital, we were given a very

⁷⁷ Pinnegar and Daynes (2007:30)

big room for us to use during the course of the research as our meeting place. We met there twice a week on Mondays and Wednesday. Initially we had agreed to meet for two hours per session but right from the beginning it did not work out. The participants enjoyed being together so we would have tea and sometimes lunch together and share more stories informally. These were some of the times when people would share about other experiences and it helped us to get to know each other well.

1.15 Research Participants

Gray (2005:82) defines a population as referring to all potential subjects in the universe who possess specific characteristics the research is interested in. The population of the study therefore consisted of HIV positive people. Since I could not have conversations with all HIV positive people, I had to draw up a sample from Gweru Provincial Hospital in Zimbabwe.

1.15.1 The sample for the study

The seven participants in this study were people living with HIV and AIDS who are receiving HIV care from Gweru Provincial Hospital. Anyone who volunteered to participate in the study was asked to give consent for the information obtained during the individual and group sessions to be used in the research report. Mouton (2001:10) states that the selection of participants in participatory action research is according to non-probability principles. Non-probability samples do not use random sampling and in this study it would be acceptable to say that the participants selected themselves through ‘accidental’ sampling (Kerlinger 1986:120). The common denominator for the sampling was, the participants were Shona speaking, they had to be willing to avail themselves twice a week for the individual and group sessions at the hospital and they had to understand that no remuneration would be made available. A small sample size of seven was used as it was suitable for an in depth qualitative, participatory action research and narrative study. The reason for such an option was the desire to come up with new rich and appropriate information which could be generalized to the population of the study. In addition the notion of choosing a small sample is supported by Shearfor and Horejsi (2006:614) who maintain that five to ten participants are sufficient when carrying out a qualitative study. Munhall (2007:88) notes that the advantage of a small sample means that a good rapport can be built between researcher

and the participants and may help to solicit more authentic responses. Six of the participants are married except for one who is a widow suggesting they had contracted HIV within marriage, the four women from their husbands and for the three men from their extra-marital affairs. They all fell in the 24-52 years age range.

I gave the seven volunteers a brief overview of the project and presented the information letter (Appendix C). After the people living with HIV and AIDS had time to familiarize themselves with the content of the information letter, I explained the terms of the study. We negotiated the ethical implications of the study, the method of work for the research, the agenda and the terms of the study. After a thorough negotiation with the people, I asked each one of them to sign a consent form and the release of information. For some reasons the participants preferred me to write down the notes during the conversations or group discussions rather than audio taping them. I was curious to know from them why they preferred notes taking to being audio taped. They stated that they were suspicious about their voices being taken somewhere they didn't know. I respected their preference and I took notes throughout the research. All the participants preferred using pseudonyms during the conversations which are also used in this research report. Their names are Mai Chipso, Mukoma Tippy, Mukoma T.J., Mukoma K.K., Mai Paida, Mother and Mainini Shupikai.

1.16 Ethical considerations

Research is viewed as a scientific human endeavor that is organized according to a range of protocols, methods, guidelines and legislation⁷⁸. Therefore, I became cognizant throughout the research that the issue of being HIV positive is a sensitive and private matter and as such I had an ethical responsibility to adhere to in order to safe guard against any harm and protect the rights of the participants in the study⁷⁹. Application for ethical clearance of the research project from Stellenbosch University Ethics Committee through the Faculty of Theology Departmental Ethics Committee (DESC) was submitted and all the protocols were followed (Appendix A). After the DESC reviewed my application and having been satisfied that the research would cause no harm to the research participants, an application letter requesting for permission to carry out

⁷⁸ Gennish and Lacey (2010:212)

⁷⁹ Roger (2008:180)

the research in Zimbabwe at the Gweru Provincial Hospital was issued to me to take to the responsible authorities (Appendix B). Since the study was to be carried out at the Gweru Provincial Hospital, in Zimbabwe permission was sought from the Provincial Medical Director to conduct this research (Appendix D). After being informed by the Medical Provincial Director that there was need to further seek permission to do research in a medical hospital, I then proceeded to seek for permission to conduct the research from the Medical Research Council of Zimbabwe (Appendix E).

Brink (2006:31-36) highlights the principles of research as, respect for persons, beneficence (do-good), non-maleficence, justice, informed consent, confidentiality and anonymity. These were applied during the study. Informed consent was sought from all the participants in the study based on an understanding of the possible harm and risk of participating in the study (Appendix C). Participation was entirely voluntary and participants were asked to sign the consent forms after adequate information had been given. Confidentiality of all the information obtained during research process rested with me. The co-researchers were assured that the information given would be kept confidential. Any information that was obtained in connection with this study that could be identified with the participants remained confidential and would be disclosed only with the participants' permission or as required by law. The participants were assured that the information collected during the project would be securely stored in a locked filing cabinet and would be destroyed after concluding the project.

I was committed to doing ethicizing research (Kotze 2001:25) and found participation a very helpful value and practice. The aim was to do research with the participants who were to be the primary beneficiaries of the research. They had the opportunity to negotiate all the aspects of the research. Hence participatory ethicizing was done, meaning we co-created the understandings, realities and decisions we made. In this regard, the unconventional term, "participants" is used instead of research subjects. I need to acknowledge that in the early stages of the research journey, authentic participation did not take place. I had to decide on the research topic in the light of my personal curiosity. I had prescribed the research question, aim and goals of the research. I had also made tentative decisions around the structure of the research journey. Much of what I had decided needed to be negotiated with the participants. We did this during our initial

sessions at the hospital after the seven participants had volunteered to be the research participants.

A critical and ethical consideration was the strong desire to uphold the maxim ‘above all do no harm.’ This meant ensuring that participants were in no way re-traumatized. White (1995:87) emphasizes that re-traumatisation is not acceptable within a therapeutic context. Holding this awareness meant creating space for “checking” with the participants how they were in terms of the conversations taking place and encouraging them to take responsibility for their own level of comfort, distress and emotions. Debriefing sessions were conducted after the conversations in order to help the participants to work through the aftermath of the conversations in turn minimizing emotional harm. During debriefing, participants were given a chance to talk about their feelings and thoughts evoked during the conversations and I helped them through counselling to step out of the group role. On the other hand counselling was also done to enable the participants to continue with their daily lives without disruption due to the painful emotions that the conversations could have evoked.

Participatory consciousness made me aware of not wanting to gain new knowledges at the expense of the participants. McTaggart (1997:4) warns against the “exploitation of people in the realization of the plans of others.” I found it necessary to work with the question, “who is benefitting?” (Kotze, Myburg and Roux 2002:18) as it foregrounded the commitment to a participatory action research that would ultimately be primarily of benefit to the participants. I took cognizance of Kotze and Kotze s’ (2001:7) words as they informed my position, “a commitment to do pastoral care as participatory ethical care immediately challenges us not to care for but to care with people who are in need of care.”

I was acutely aware that I, too would be changed as we journeyed together in this research journey and that we would all find ourselves transported to places and into territories of life and identities that we could not have imagined. White (1995:7) confirms, “therapeutic interactions are a two-way phenomenon. We get together with people for a period of time over a range of issues and all of our lives are changed.” For this White (1999:73-74) clarifies katharsis, in its classical sense as,

People being moved in the sense of being transported to another place where they could not have otherwise been as a result of witnessing a performance of life that is 'gripping' of them. In this context, katharsis is understood to be a response to, "witnessing powerful expressions of life's drama" and a way of making meaning out of our own responses.

This understanding of katharsis helped me to be vigilant and reflexive throughout the research journey. The results of this project would be published. At their request details, names and places have been distorted to ensure anonymity. They chose to use pseudonym of their own choice so that personal identities of the participants would be secure even in cases where information could be shared by third parties. No coercion or deception was done in order to make the participants participate in the study. A copy of the research report will be made available to each participant.

1.17 Thesis Outline

CHAPTER TWO: HIV AND AIDS EPIDEMIOLOGY, EVOLUTION AND RESPONSE IN ZIMBABWE

Chapter two aims at highlighting the HIV and AIDS epidemiology and its evolution in Zimbabwe and the national response to the pandemic with the view of trying to understand the context in which the spiritual needs and concerns of people living with HIV and AIDS who are receiving care within the primary health care delivery system in Zimbabwe are embedded in. The chapter based on literature review, discusses how the government of Zimbabwe (GOZ) has responded to the HIV pandemic and the role played by international organizations in mitigating the impact of HIV and AIDS on the people. The main focus therefore is on the Zimbabwe National AIDS Policy (ZNAP) and how the care and counseling of people living with HIV and AIDS within the Primary Health Care delivery system is done. I conclude the chapter by discussing what I considered as the missing gap in the (ZNAP) which is the puzzling, strange silence on the spiritual care of people living with HIV and AIDS as part of the holistic approach to their care. To enhance the background to the study, the historical context of Zimbabwe is briefly highlighted.

CHAPTER THREE: STORYING THE UNSTORIED: THE PROBLEM SATURATED STORIES

The aim of this chapter is to give “voices to the voiceless” by “storying the unstoried” experiences of being HIV positive as backdrop to identifying and investigating the participants’ spiritual problems and needs and how they could be addressed within the primary health care delivery system in Zimbabwe. Part of the purpose of the chapter was to deepen the co-researchers’ own understanding of their HIV and AIDS experiences. The stories in this dissertation are true although names and minor details have been changed to obscure identities. I intentionally refrained from interpreting or commenting about each story and each story is treated with dignity and as unique and important. The stories of the participants represent their own experiences and are not necessarily representative of the lives and experiences of other people living with HIV and AIDS in Zimbabwe or anywhere else on the globe. Therefore, in this chapter I gave the participants a voice, which could be heard among the many other voices that speak of the experiences of living with HIV and AIDS.

CHAPTER FOUR: WEAVING THE THEMES TOGETHER: CO_CONSTRUCTING NEW KNOWLEDGES

Chapter four focuses mainly on answering the first part of the research question by identifying and investigating the spiritual problems and spiritual needs of people living with HIV and AIDS from their perspectives. Part of the purpose of this chapter was to deepen the co-researchers’ own understandings of their spiritual issues and concerns under consideration to the extent of co-constructing new knowledges about these spiritual issues. The social construction idea that realities are socially constructed, deconstructed and re-constructed was successfully implemented to achieve this goal. The chapter captures the explanations made by the participants of the indescribable and unimaginable spiritual pain experienced in their spirits which the traditional healers, the faith healers or prophets have failed to address. The participants also expressed how the spiritual pain manifests in their lives. The seven participants were able to articulate what their spiritual needs were. It emerged that the participants’ stories of pain, suffering and questionings, although different, their spiritual needs were the same. Their spiritual needs were stated as spiritual healing to the experienced spiritual pain. However, the spiritual healing was interpreted differently by the participants. The participants clearly stated that only God can heal them and

this emerged as the unique outcome on which all their stories converged for building the alternative stories which are re-authored in Chapter Five.

CHAPTER FIVE: THE QUEST FOR SPIRITUAL HEALING: SPIRITUALITY AS A HIDDEN TREASURE

This chapter focused more on answering the second part of the research question having established in the previous chapter that people living with HIV and AIDS quested for spiritual healing which was necessitated by the indescribable and unimaginable spiritual pain expressed in all their questionings. This chapter describes how spiritual healing as a spiritual need of persons living with HIV and AIDS can be addressed using narrative therapy. The goal of pastoral care was not to counsel or to take away the disease or to offer a ‘healthy dogs’ - myths about quick fix solutions and things that work but to mobilize the spiritual resources within the participants to enable them to cope. The idea was therefore to empower those living with HIV and AIDS to discover their own spiritual potentials which would enable them to work through their spiritual pain. My position as a pastoral caregiver was not only to participate in co-constructing the alternative stories but also care in a way that could heal and not hurt. My purpose and desire of this study was to enable the participants discover new ways of authoring their lives through participation in the study as the experts of their lives. A strong suggestion that emerged from the research was that spiritual care of persons living with HIV and AIDS who are receiving care within the PHC is needed and it is possible as long as space can be created and the qualified personnel are made available to the people living with HIV and AIDS. The wish of participants that their spiritual well-being be considered in their health care adds momentum to this suggestion. Narrative therapy emerged as the therapeutic approach which can be used by pastoral caregivers to journey with patients on their personal spiritual pathways to spiritual healing.

CHAPTER SIX: FOLDING BACK: REFLECTIONS ON THE RESEARCH JOURNEY

The purpose of this chapter is to reflect on the research journey and its effects on me as the researcher/therapist as well as on the research participants. New questions are posed and challenges experienced during the research process are discussed as the reflection was done. Although reflection was done throughout the study as the journey progressed, the purpose of this

chapter is therefore to emphasize the importance of reflection as an important learning activity and as a continuation of the co-research. It is through the experiences of reflecting on our experiences that we make meaning of it. The reflection in this chapter was done according to how the philosophical ideas from the theological and theoretical frameworks influenced the research journey in the quest to find spiritual healing from the spiritual pain experienced by people living with HIV and AIDS. The chapter gives a short collection of what I have learnt together with the participants throughout the journey of the research. The reflections make it clear that the re-authoring of alternative stories is an ongoing process and spiritual care never ends because every ending is a beginning and out of incessant storytelling new depths and meaning are found. However as in all journeys, there are landmarks that indicate achievements, places of transfer or starting new directions or turning around. Hence this research journey may be regarded as a landmark that indicates a new direction in the participants' journey towards spiritual healing.

CHAPTER SEVEN: CONCLUSIONS AND RECOMMENDATIONS

This chapter gives the conclusions and the recommendations made from the study. The research question, the aim and goals of the research are re-visited. Then the recommendations are made in line with the strong suggestions which have emerged from the research journey, that in the light of the stories shared by the participants in this study, it became evident that there is an existing need within the Primary Health Care delivery system in Zimbabwe to provide spiritual care to people living with HIV and AIDS. The research aimed at co-creating a therapeutic framework in which those living with HIV and AIDS as well as those working with them be empowered to re-author the stories of patients' lives around their self preferred images. Hence a spiritual and pastoral approach to healing emerged as a therapeutic framework which can be used in offering spiritual care to people living with HIV and AIDS. Narrative therapy emerged as the approach which can be used to journey with people living with HIV and AIDS pastorally in their quest to spiritual healing. This chapter was based on the above suggestions as the conclusions and the recommendations are made.

1.18 Conclusion

Chapter one gives an overview of the research journey by highlighting the Zimbabwe HIV and AIDS scenario as backdrop to the research and how the Government of Zimbabwe (GOZ) started responding to the impact of HIV and AIDS through the Ministry of Health and Child Welfare by establishing the National AIDS Council (NAC) to coordinate the national HIV and AIDS programmes. The NAC finalized two important policy documents to guide the national response to the pandemic which are, *The National Policy on HIV and AIDS for Zimbabwe and the Strategic Framework for a National Response to HIV and AIDS*. In this policy the care of people living with HIV and AIDS is integrated into the primary health care delivery system. The National Policy on HIV and AIDS policy of Zimbabwe advocates for a holistic approach to care of people living with HIV and AIDS. However the policy is silent about the spiritual care of people living with the disease. And to me excluding the spiritual problems and needs of people living with HIV and AIDS is a huge gap which called for research. My argument is that excluding spiritual problems and needs of people living with HIV and AIDS defeats the whole purpose of a holistic approach to the care of persons living with HIV and AIDS.

Hence throughout the research journey, I wanted to learn from the people living with HIV and AIDS what could be their spiritual problems and needs from their perspectives and how they could be addressed within the primary health care delivery system in Zimbabwe. Therefore the aim of the study was to co-create a spiritual and pastoral approach to spiritual healing with people living with HIV and AIDS which is contextual and relevant to the Zimbabwean context as part of the holistic approach to care of people living with HIV and AIDS within the primary health delivery system. In this regard, the chapter discusses the theological and theoretical framework of the study. I also discuss the methodology of the research hence the research journey became a qualitatively oriented practical theological participatory action research done through the therapeutic lens of narrative therapy.

Chapter Two, which is a literature study proceeds on the assumption that HIV and AIDS is a disease of society and not only a medical issue therefore the context in which the pandemic is embedded becomes important in understanding and investigating the spiritual problems and needs of people living with HIV and AIDS in Zimbabwe.

CHAPTER TWO

THE HIV AND AIDS EPIDEMIOLOGY, EVOLUTION AND RESPONSE

1.0 Introduction

Chapter two aims to provide the contextual background to the research topic and research question. It proceeds on the understanding that HIV and AIDS is a global threat with very locally down to earth consequences. The assumption therefore is that HIV and AIDS is a disease of society and not only a medical issue. Hence the context in which the pandemic is embedded becomes important in understanding the evolution of the HIV epidemic and the widely diverging HIV and AIDS pandemics in Africa or anywhere else. In this regard, the chapter discusses social, economic and political determinants of HIV and AIDS in Zimbabwe. HIV and AIDS as a social issue, has provided reactions of panic among the communities and revealed social fissures, inequalities discriminations and stigmatization of people living with HIV and AIDS in society. From the foregoing, the chapter highlights the prevalence rate of HIV in Zimbabwe which has declined amidst all the crises Zimbabwe is going through. In light of the declining HIV prevalence rate, I discuss how the GOZ responded to the HIV pandemic and the role played by international organizations. The main focus therefore, is on the Zimbabwe National AIDS Policy (ZNAP) and how the care of people living with HIV and AIDS within the Primary Health Care delivery system is formulated. I conclude by discussing what I consider as the missing gap within the (ZNAP) which is the puzzling silence on the spiritual problems and needs of people living with HIV and AIDS in terms of providing a holistic approach to the care of people living with HIV and AIDS. To enhance the contextual background to the research, the following section discusses the geographical and historical context of Zimbabwe.

2.1 Geographical and historical context of Zimbabwe: An overview

Zimbabwe is a landlocked country situated in the Southern African subcontinent with an estimated population of 13 875 574 of which 48% are male and 52% female⁸⁰. The country of Zimbabwe is divided into ten administrative provinces as indicated in Figure I below which

⁸⁰Rembe (2006:234)

include the two major cities Harare and Bulawayo, fifty nine rural districts and 1 200 municipalities⁸¹.

Figure 1: The map of Zimbabwe showing the provinces and towns



Source: <http://www.mapsofworld.com>

⁸¹Dambisya (2007:7)

This information is important as it provides a backdrop to understanding how the PHC delivery system is organized and structured in Zimbabwe as well as indicating the area of the study which is Midlands Province. Midlands Province has an area of 49,166 km² and a population of approximately 1.5 million (2002). Gweru is the capital of the province and it is home to various peoples and as a central point in Zimbabwe, it has a blend of Shona, Ndebele, Tswana, Suthu, and Chewa among various other languages spoken in Zimbabwe. Gweru is the third largest City in Zimbabwe. The research study was carried out at Gweru Provincial Hospital, which is the provincial capital city of Midlands Province.

Zimbabwe was a former British colony but the struggle from colonialism in Zimbabwe was hard worn with human casualties and did not end in 1980 with the independence of Zimbabwe from colonial rule.⁸² Parirenyatwa in the (MOHCW) (2004: iii) report admits that the HIV and AIDS epidemic is the most serious challenge faced by Zimbabweans since independence. Parirenyatwa in MOHCW (2004:1) continues to highlight that, life expectancy at birth has fallen below levels that existed at independence, wiping out the gains of a generation and the consequences of the AIDS pandemic are going to be around for decades. HIV and AIDS has made its in road into all towns, cities and even to the remotest parts of the country, inflicting not only physical pain as a disease, but emotional, psychological and existential crisis raising questions which are far from being purely medical or clinical. To this end, the hunger and thirst for care and counselling among all segments of the population in Zimbabwe can never be overstated considering that there is no cure for the deadly scourge. Makumbe (2009:1) concurs that post independence struggle has also had its own casualties, which are difficult to quantify as people are now dying from poverty, HIV and AIDS related deaths. In what follows, I discuss the epidemiology of HIV and AIDS in Zimbabwe as a backdrop to understanding its evolution and how the nation has responded to the pandemic.

⁸²Saunders in Abiloye and Majongani (2008:12) reminds us that in Zimbabwe up until 1980, the struggle focused on the achievement of majority rule, the control of the government and state by the people to make sure that the government represents and serves the best interests of the nation.

2.2 HIV and AIDS in Zimbabwe: An overview

According to the Avert report (2009:1), the first reported case of AIDS in Zimbabwe occurred in 1985. The same report states that, by the end of 1980s around 10% of the adult population was thought to be infected with HIV and this figure rose by 1997, peaking and stabilizing at 29% between 1995 and 1997. According to the Zimbabwe Ministry of Health and Child Welfare (MOHCW) (2010:1) report, it is approximated that 1.8 people in Zimbabwe live with HIV and AIDS and about 90% of the affected are not aware of their status. It is approximated that about 600 000 of those carrying the virus have the signs and symptoms of AIDS and require various degrees of care and support. The same report approximates that an average of 2 500 people die as a result of HIV and AIDS per week and life expectancy has fallen from 60 years in 1990 to 43 years due to HIV and AIDS. On the other hand since this point, the HIV prevalence is thought to have declined, making Zimbabwe one of the first African countries to witness such a trend. The MOHCW (2010:11) report indicates that according to the government figures the adult prevalence was 24.6% in 2003 and fell to 15.3% in 2007.

In Zimbabwe, as in other countries, international blame and counter blame caused government attitudes towards HIV to become increasingly ambivalent and secretive⁸³. Secretiveness affected the quality of AIDS information provided to the public and at a personal level HIV and AIDS remained surrounded by secrecy and denial. So, too, Arisunta (2010:1) argues that, as the general public was yet unable to recognize symptoms of HIV related disease (except perhaps ‘slimming’ or extreme emaciation in late stage disease) the reality of a rapidly expanding AIDS epidemic remained largely hidden, though anxiety about the HIV was common. Changes in sexual behavior remained insufficient to curb the epidemic and HIV became highly stigmatized in Zimbabwe.

Accordingly, as in many other countries, the AIDS campaigns in Zimbabwe relied heavily on one way education methods and factual information about HIV summarized in slogans such as ‘AIDS kills and has no cure’ and simplistic behavior advice mainly the Abstinence, Be faithful and Condomise (ABC) model of prevention. Sibindi and Meursing (2000:17) argue that

⁸³Sibindi and Meursing (2000:17)

continued emphasis on un-contextualized ‘ABC’ approaches needs to consider the local context in order to be successful. These HIV and AIDS campaigns did not take into account the complexities of the social, economic, political and cultural context of sexual behavior such as women’s lack of power in sexual decision making, cultural norms with regards to sexual behavior⁸⁴. The idea of translating one type of prevention or education instrument from one language into another language, without considering other cultural and power issues is likely to be ineffective at best. Hence, the challenge in fighting the HIV and AIDS pandemic becomes, how can scientific theories developed in one culture be exported into another?

To this, Paroske (2009:158) reflects that African and Western AIDS is not the same phenomenon and scientists acknowledge differences between Western and African AIDS in both, mortality rate and pattern of infection which they called HIV_1 and HIV-2. When we now look at the HIV and AIDS pandemic, as a social phenomenon, we ask ourselves why do some populations have much AIDS, while it is rare in others and why do some have HIV-1 and others HIV-2? In this regard, Decosas (2002:3) observes that,

there seems to be no recognizable pattern of HIV prevalence even in Sub-Sahara because causal inferences on the basis of average behavioral profiles can be made but when we arrive at behavioral explanation, we still do not know why people at this time in this particular location behave in a way that put their health at risk. Without this knowledge our ability to intervene is restricted to exhortation for behavioral changes an approach of doubtful effectiveness.

The complexities of this situation was stated bluntly by the former President Thabo Mbeki of South Africa in his opening speech of the XII International Conference in Durban South Africa in 2000 as he maintains that his government was fighting AIDS by adopting public health programs that addressed larger socio-economic concerns beyond the distribution of ARV drugs as he states,

“as I listened and heard the whole story told about our country, it seemed to me that we could not blame everything on a single virus.As an essential part of our campaign

⁸⁴Sibindi and Meursing (2000:17)

*against HIV and AIDS we are working to ensure that we focus properly and urgently on the elimination of poverty among the millions of our people*⁸⁵.

In responding to the above comment by the former President of South Africa, Paroske (2009:157) is of the opinion that the assumption here was that, poverty contributed to the development of opportunistic infections and hence when the ANC government fought poverty, it was also fighting AIDS at the same time and providing ARV drugs was not the only way of fighting the AIDS pandemic. Paroske (2009:157) argues that, the Western orthodox scientists were so forceful in their rebuke of President Mbeki and unbending in their dismissal of dissent. Hence, the Durban declaration completely ignored Mbeki's political argument about apartheid or colonialism contributing to the evolution of the HIV and AIDS pandemic in Africa, as five thousand scientists in their collective mind signed the declaration against Mbeki's remarks on HIV and AIDS in Africa. In the same vein, Decosas (2002:4) is of the view that Mbeki had made an intelligent remark as a careful observer, yet it fuelled a storm. But even the critics of Mbeki have to admit that they have neither the theory nor the data to explain the widely diverging pandemics of AIDS epidemics in Africa, or anywhere else.

On the same note, Decosas (2002:5) has observed that when it comes to research on AIDS, our gaze remains obsessively focused on the individual and his/her responsibilities, where biomedical activities are given premature credit for what they can achieve in HIV control. Most efforts to address AIDS in Africa are based on reductionist analyses of causation at the individual level although there is so much lip service paid to the 'social' dimension. In Decosas' opinion there seems to be more commercial interest in devising and implementing programmes centred on individuals in the pharmaceutical and biomedical sector, but even non-profit contractors delivering HIV and AIDS programmes for large donor agencies, have an economic interest in the growth of these projects.

From the foregoing, it follows that the context in which HIV and AIDS is embedded needs to be examined. All societies are complex and multi-faceted, having innumerable features that might be measured and tested for their potential contributions to the configuration of health and

⁸⁵Decosas (2002:4)

disease. UNAIDS (2001:21) acknowledges that the political, social and economic context determines the HIV pandemic. Hence Gwemende (2010:10) ascertains that in Zimbabwe the HIV and AIDS pandemic cannot be understood outside the social, economic and political context of Zimbabwe, which to some extent determines the evolution of HIV and AIDS in Zimbabwe. In making this case, I acknowledge that the social, economic and political determinants of HIV and AIDS are intricately intertwined and their demarcation maybe very difficult. Hence in what follows, I will endeavor to give them separate subheadings but in the discussions, they may be examined in an intertwined manner.

2.3 The social determinants of HIV

The highest mode of HIV transmission in Africa and in Zimbabwe is through penetrative heterosexual intercourse or contact. Faiclough (1995:131) is of the opinion that the societal social ideology surrounding sex, gender and power relationship is inevitably reflected and constructed in HIV and AIDS discourses. Faiclough adds that there is a dialectical relationship between discourse and the society and how gender and sexuality are constructed in the HIV and AIDS discourse has some bearing on the evolution of the pandemic. I will discuss the gendered dimension of HIV and AIDS in Zimbabwe and how it has fueled and sustained the pandemic.

2.3.1 Gendered Dimension

Gender concerns expectations and norms of appropriate male and female behaviours, characteristics and roles shared within a society. It is a social and cultural construct that differentiates women from men and defines the ways they interact with each other. Sexuality is the social construction of a biological drive which includes, whom to have sex with, in what ways, why, under what circumstances and with what outcomes, Sexuality is influenced by rules both explicit and implicit imposed by the social definition of gender, age, economic status and ethnicity.

Kambarami (2006:1) purports that the Zimbabwean cultural practices about gender shape and perpetuate gender inequality and strip women of any form of control over their sexuality due to the fact that, custom in Africa is stronger than law and religion. Although discrimination against and exploitation of women are global phenomena, their consequences are more tragic in some

parts of the globe particularly in African countries. Women are under social control and scrutiny which restricts what they can say, where they can go and with who. In Zimbabwe sexuality is political because it is organized into systems of power, which uphold some individuals and activities while punishing and suppressing others. For example, Mhlongo (2009:7) is of the opinion that many cultures express leniency on male sexual behavior but are very prescriptive when it comes to female sexual behavior. In the Zimbabwean culture males are free to experiment sexually at will before marriage, whilst females have to preserve their virginity for marriage or risk tarnishing the family image since the son-in-law will not pay “*mombe yechimanda*” or the mother’s cow as she will be considered damaged goods. This is a cow offered by the son-in-law as a token of appreciation for marrying a virgin to the mother of the bride. This custom holds value in the Shona culture and in some parts of Zimbabwe, where virginity tests are still conducted up to date. Mhlongo (2009:7) adds that, female sexuality is largely in the hands of males in the African culture because it is patriarchal.

It should be noted therefore that since independence in 1980, the Zimbabwean government has shown commitment to changing the plight of women. At independence, women were for the first time in the history of the country officially recognized as an oppressed group and as such, were the target of a conscious government policy to change their situation. Townshend (2008:25) asserts that through legal reforms like legal age of Majority Act of 1982 and the Domestic Violence Bill of 2006 which has now become law, the Zimbabwean government has demonstrated its solidarity with the women. The GOZ has made remarkable strides in addressing gender inequalities in Zimbabwe⁸⁶. However, to have this Bill passed as a law was not an easy task for the parliamentarians as can be noted below from the contribution in parliament on the deliberations of the bill by Timothy Mubaiwa, a Movement for Democratic Change (MDC) member cited by Townshend (2008:26),

I stand here representing God Almighty; women are not equal to men... It is a dangerous bill and let it be known in Zimbabwe that the right, privilege and status of men is gone. I stand alone and say this Bill should not be passed in this House. It is a diabolic Bill. Our powers are being usurped daylight in this house.

⁸⁶Dambisya (2007:15)

Townshend (2008:26) adds that Timothy Mubaiwa also pointed out that, there should be laws concerning how women dress as some of their dressing is too inviting and those women leaders in government, judiciary and Parliament should be exemplary by at least marrying. On reflecting on the above comments by Timothy Mubaiwa, Townshend affirms that these statements reflect an attitude of mind that believes that, women are blamed for any lack of morals shown by men hence are sometimes blamed for infecting partners and children with HIV and AIDS. In the case of rape, some women are blamed for causing it.

The commitment of the Government of Zimbabwe (GOZ), to raise the status of women has never been in question because as a member of the United Nations and African Union the GOZ ratified a number of regional and international instruments and protocols that had a strong bearing on the status of women in the country. The GOZ has a Ministry of Women Affairs that demonstrates the unwavering commitment of the GOZ to up lift the life of women. The idea was to eliminate all customary, social, economic and legal constraints that inhibit women's full participation in the development of their country⁸⁷. Mungwini (2007:127) on the other hand asserts that however, while this was the case patriarchal values have not died but have continued to simmer under the surface waiting for an opportunity to re-emerge. The empowerment of traditional leaders as custodians of culture and traditions by the GOZ seems to have availed itself as an opportunity for patriarchal values to reassert themselves.

Accordingly, Faiclough (1995:132) is of the opinion that, what is fundamental to both sexuality and gender is power. The unequal power balance in gender relations that favor men translates into an unequal power balance in hetero- sexual interactions, which can fuel and sustain the evolution of the HIV and AIDS pandemic⁸⁸. Therefore gender and sexuality must be understood as constructed by a complex interplay of social, cultural and economic forces that determine the distribution of power. UNAIDS (2001:25) affirms that within the HIV and AIDS pandemic, the imbalanced power between women and men in gender relations curtails women's sexual autonomy and expands male sexual freedoms. This increases both genders' risk and vulnerability to the epidemic. In addition, Arisunta (2010:4) alludes that what are often overlooked are gender inequalities in socio-economic status and patriarchal ideology around sexual practices, such as

⁸⁷ Mungwini (2007:127)

⁸⁸ Arisunta (2010:8)

abstinence, monogamy or condom use so that women all over the world find themselves at special risk of HIV infection. Women lack the power to determine where, when and how sex takes place. Furthermore, Adepaju (2008:3) argues that the situation of African women can be precarious and traumatic, suffering discrimination at various levels from birth at home, in the school, at the workplace and in the society. Socio-economic inequalities translate into unequal power relations between people and transactional sex in this context easily becomes, a means of survival and AIDS has a woman's face⁸⁹. Biological differences in anatomy between male and females have been cited as the contributing factor to women being more vulnerable to HIV infection than men. This has also contributed to fuelling and sustaining the HIV and AIDS pandemic. In the following section, I will discuss how the customary law in Zimbabwe controls female sexuality which in turn can contribute to fuelling and sustaining the pandemic.

2.3.2 Customary Law

The Zimbabwean culture has systems of controlling female sexuality which are considered normal but in this era of HIV and AIDS may contribute to the fuelling and sustaining of the pandemic. Customary law by being oral law and not written law makes it more open to broad interpretations and more powerful because of constant repetition, which empowers it and imprints it on the subconscious minds of the people⁹⁰. The customary law repetitions are accompanied by rituals that reinforce them through the repetitions of these rituals making them be seen as the natural order⁹¹ of things even over and above the written law. It is therefore very clear that, although the constitution of Zimbabwe, as the codified expression of the legal practice, declares that women have equal rights to those of men, however the same constitution also nullifies these rights by making the women subject to customary law. This enhances their vulnerability to HIV infections as well as contributing to the spread of HIV and AIDS in Zimbabwe. Below I discuss motherhood, *lobola* and marriage as some of the main systems of controlling female sexuality embedded within the customary law.

⁸⁹ Adepaju (2008:3)

⁹⁰ Townshend (2008:30)

⁹¹ Townshend (2008:7)

2.3.2.1 Marriages

Zimbabwe has a hybrid legal system composed of statutory and customary law but discriminatory customary laws continue to apply⁹². The predominance of registered and unregistered customary marriages contributes to the vulnerability of women to HIV infections. The Customary Marriage Act in Zimbabwe allows men to have as many wives as they want but does not accord the same privileges to women⁹³. Polygamy is prohibited under statutory law but is authorized under customary law and continues to be practiced. In the Zimbabwean culture, being married and therefore being someone's wife gives the woman respectability. This is so because of the strong presupposition that a married woman is necessarily constrained in her behavior, while a single woman living alone is perceived as a freelancer who has no brakes in her sexuality⁹⁴. All the women in the study claimed to have had only one sexual partner in all their life and this is in line with previous researchers on HIV transmission in heterosexual relationships, which state that 60-80% of African women with HIV had only one partner.

Bamett and Whiteside (2006:199) still in the same line of argument, state that it is a fact not repeated enough that 90% of women who have been infected with HIV have only ever slept with one man in their lives, their husbands. Hence, it was confirmed in this study that women are exposed to the HIV and AIDS pandemic through the actions of their husbands or sexual partners. The behavior that puts women at greatest risk for HIV infection is unprotected sex within marriage and the women participants in this study related to that fact. Married women's HIV risk denial, combined with persistent gender inequality, may have greater implications for the spread of marital HIV. From the research participants' stories, men's sexual behavior presents a public health problem. Hence, to suggest that we can help married women protect themselves by empowering them to negotiate for condom use, is suggesting that we can change the outcome of gendered inequalities in power without doing anything about the actual inequality. The point I want to make here is that, the role of married men in sustaining heterosexual transmission of HIV has been insufficiently explored. Hence, most women now consider being married to be the biggest HIV and AIDS risk factor in their lives because in their situations, they cannot protect

⁹² Kalhorn (2011:110)

⁹³ Arisunta (2010:21)

⁹⁴ Mungwini (2008:205)

themselves as was the case with the women participants in this research. There seems to be a better chance of a woman to protect herself against HIV outside marriage than within marriage. Marriage has become potentially dangerous as women are reportedly contracting HIV and AIDS within the marriages⁹⁵.

2.3.2.2 Motherhood

Motherhood in Zimbabwe is the traditional way of defining a woman's status. A woman is seen as a woman only if she is a mother. Hence, child bearing is a culturally constructed essence of womanhood and a control feature in the construction of female selves to the extent that motherhood is a cherished self identity by many women⁹⁶. Hence women are called by their children's names. However, the mother image reinforces gendered roles and ultimately reproduces patriarchal prescriptions. Since motherhood is considered honorable, women have come to enjoy the role without questioning its oppressive side. Townshend (2008:33) is of the opinion that once married there is no question about mothering and that has become one of the major challenges in this era of HIV and AIDS as this can influence the evolution of the HIV and AIDS pandemic. Many women may end up having children despite their husbands or themselves being HIV and AIDS positive. In this study this was confirmed by Mai Paida in her story (see 3.3) as she stated, *I want to have another child. What must I do? I really want another child*. Her desperation to have a child when she is HIV positive may confirm the idea that having children is an honor to be cherished.

To further confirm this thought, all the women in the study preferred being called by the children's names as their pseudonyms even those without children. For instance, Mai Paida means, the mother of Paida. Paida is assumed to be the first born child. In line with this argument, Gambrone (2003:83) came to the conclusion that children are a source of strength to HIV positive women. If this argument is true, therefore collaborative partnership between family planning, HIV and AIDS services and HIV counseling as part of the integrated system, becomes imperative in providing early intervention services, which will relieve the anxiety about reproduction in an HIV infected woman as well as to reduce HIV transmission and break-up.

⁹⁵ Townshend (2008:211)

⁹⁶ Mungwini (2008:207)

2.3.2.3 Lobola/Bride prize

Muzvidziwa (2001:154) is of the opinion that while traditional Shona marriage has undergone many changes over the last 100 years, an important principle that has survived the test of time is payment of the bride prize (*lobola*). It appears as if a woman for whom *lobola* has not been paid is, according to Shona culture, not a legitimate wife but one of whiling up time. According to Townshend (2008: 211) *lobola* is a structure that has become a principle in Zimbabwean marriage and by constant repetition, it is regarded as normal achieving fixity, and stability that cannot be challenged or questioned. Townshend (2008: 211) sees *Lobola* as a form of male control over women's bodies. This is supported by one lady interviewee in Townshend's (2008:211) research in Zimbabwe who stated, "yes he forces me to have sex many times especially after quarrelling, even when I am swollen, he wants to have sex, If I say I am not enjoying it when I am like this he says," You forget that I paid *lobola*" and he forces me." The attitude of men can be interpreted to mean that, since they paid *lobola* they now have exclusive rights over their wives. Men are the ones to decide whether to use a condom or not for protection, where and when to have sex.

Male domination has become so rooted in people's collective unconscious that they no longer see it. In Zimbabwe many women still accept their inferiority status as normal and often it is these women themselves who resist change. Divorce in the Zimbabwean culture is consent of both families when a woman has committed adultery but if it is a man, this does not apply. Other reasons for divorcing a woman are barrenness and denial of sex to the husband. The fact that Zimbabwean men traditionally see themselves as the breadwinners, contributes to their view that women are subordinate and always answerable to them. This has often led to domestic violence as well as making women vulnerable to HIV infections hence fuelling the pandemic.⁹⁷

In the light of the above discussion, it is clear that future HIV and AIDS empowerment programmes for Zimbabwean women should be target specific and contextual, based on handing over power to interpret, analyze and come up with solutions for themselves⁹⁸. Empowerment occurs when women realize that some important aspects of their lives can be different and that

⁹⁷ Bourdieu in Townshend (2008:40) explains that men with symbolic capital use symbolic power to control other people both their bodies and their beliefs.

⁹⁸ Akerkar (2001:2)

change is possible. In this regard, both men and women should be actively involved in all empowerment programmes. Hence a human rights approach must be emphasized, which entrenches the principle that governments are accountable to the people who voted them into power. This will mean that each time a woman is forced to have unsafe sex; it will be seen as a violation of her civic rights.

On the other hand, women should come up with research agendas and topics that pertain fully to their everyday experiences so that they can get solutions to their immediate concerns. When the people who are affected by development issue become part of the process of defining the problem and finding solutions, this will give them power to shape their destinies in ways that reduce their risk to HIV and AIDS. Similar participatory research for men is needed also because men's vulnerability to HIV infection and risk taking is heightened by cultural attitudes that allow sexual promiscuity and by the number of predominantly male occupations that entail migration, which disrupts family life. HIV programmes should also promote men's understanding of their role and responsibility with regard to protecting women's health and reducing the transmission of sexually transmitted diseases.

Furthermore, women have a right to knowledge but most of them live in ignorance of laws and policies that directly affect their lives. Hence educational seminars and workshops maybe conducted through HIV programmes for both men and women. There is need also for a gender based response which takes into account the inequalities that are fuelling the spread of HIV and AIDS in Zimbabwe. From the foregoing, what follows is the discussion on what I consider to be the economic determinants of HIV and AIDS in Zimbabwe

2.4 The economic determinants of HIV

According to Adepaju (2008:3) in spite of Sub-Saharan Africa being rich and with diversified resources, it is the world's poorest major region and most of the continent's countries including Zimbabwe, are ranked low in terms of human development indicators. Illiteracy remains high and health conditions continue to deteriorate. Zimbabwe as a country faces an array of challenges among them HIV and AIDS pandemic, brain drain and the widely documented economic and political crisis that have stalked the country in the post 2000 period. In light of the

challenges that are regarded as severe, it is important to discuss HIV and AIDS in Zimbabwe within the perspective of the prevailing political and economic context in order to understand how this context has fueled and sustained the pandemic.

According to the Zimbabwe Country of Origin Information Report (2011:18) Zimbabwe generally ranks poorly in global comparisons of economic competitive e.g. in the World Bank's "doing Business" rankings for 2011 Zimbabwe is number 157 out of 183 world economies. According to the same report, the GOZ estimates that the economy grew by 8.1% in 2010 and projects 9.3% real growth in 2011 and this is attributed to the adoption of the multicurrency monetary regime in 2009 under, which nearly all business is done in US Dollars and has brought stability and restored business confidence. However, as pointed earlier Zimbabwe is one of the poorest countries globally and in light of this assertion, it becomes imperative to examine two major issues that might have contributed to this poverty and implicitly or explicitly fuelling and sustaining the pandemic in its evolution in Zimbabwe.

2.4.1 The land question

The past years in Zimbabwe have been characterized by repression, economic and social disarray, accompanied by violence whenever elections are held⁹⁹. Among the consequences of such a context are hyperinflation, shortages of basic commodities, mass migration of skilled workers, and a restriction in social spending, donor flight, increasing poverty and 80% unemployment. These challenges have had a direct negative bearing on all aspects of health care to include the HIV epidemic. The land issue in Zimbabwe plays an important part in agriculture in the economy and nutrition of the Zimbabwean people. Agriculture is Zimbabwe's economic mainstay and was once described as "the much vaunted backbone of the economy"¹⁰⁰. In this regard, Litwin (1995:5) once stated that, "when agriculture sneezes, the Zimbabwean economy catches a cold." In the post 2000 period, the agricultural sector sneezed and the country's economy did not only catch a cold it literally came to a stand¹⁰¹. Among the factors contributing to this were the political and economic challenges that the country experienced during this period

⁹⁹ Moyo et al (2008:41)

¹⁰⁰ Sachikonye (1992:90)

¹⁰¹ Mutasa (2011:3)

largely stemming from the internationally politicized fast track land reform program that the country implemented from July 2000 to August 2002.

Kalhorn (2011:25) adds that, the land program shook the country socially, economically and politically and the implementation of this program led to the international isolation of the country. The country's land question is deep rooted in its colonial past. When the European colonizers settled in the country in the 1880's, they alienated high potential zones pushing the natives to the periphery of the good soils. When the country gained its political independence in 1980, the new government was faced with a huge challenge of redressing the land issue. With the increasing discontentment among the people the land invasion that started in 2000 became the entry point of the grievance discourse¹⁰². According to Dambisya (2007:9) the WHO Humanitarian Assistance and Recovery Programme (HARP) carried out a study in May 2002 in Zimbabwe, and the results estimated that as much as one million people living in these new resettlement areas have no access to basic health services and information. Hence lack of basic information on HIV and AIDS prevention, care and treatment for the people in the new resettlement areas may have contributed to the spread of the HIV infection as well as fuelling and sustaining the evolution of the pandemic in these areas and beyond.

The land issue has always been the epicenter of national struggles in Zimbabwe. Auret (1990:5) alludes that by 1899 nearly 16 million acres of good land had passed into white settler hands and the 'hunger' for land was not quenchable until it was satisfied through the Land Appointment Act of 1920, which divided land along deep racial lines so much that about 1000 acres of land per head were set aside for 48 000 white settlers. In making this case Maposa et al (2010:195) further establish that this vicious land alienation was once again a major factor in the eruption of the Second Chimurenga War (1965-1980) just as the First Chimurenga (1896-1897). Maposa et al further explain that the second Chimurenga was mainly fought under the banner of *ivhu kuvanhu* that is restoration of land to the people. In the nationalistic politics of the 1960's and 1970's every black person was *mwana wevhu* to mean son of the soil which is land and to deny this 'son of the soil' land ownership was perceived as a violation of basic human rights.

¹⁰² Makumbe (2009:1)

It was only in February 2000 that a gigantic programme of commercial land distribution was unleashed. This followed the failure of the government sponsored constitutional referendum in January 2000, Third Chimurega¹⁰³ and popularly known as *Hondo yeminda* the struggle for the Land. However, Sanders (1990:7) is of the opinion that the acquisition of mostly marginalized land and poor technical and infrastructural support for many settlers, have resulted in poor health and nutrition status, which has a direct impact on the HIV and AIDS pandemic for many Zimbabweans. To sum this discussion, Moyo (2005:4) points out that since 1980, over 80% of Zimbabwe's rural populations have continued to depend on farming. Land policies since 1980, have failed to redress the need among the poor for the effective control of production assets such as fertile land, access to irrigation water, infrastructures and natural resources for consumptive and productive use. Moyo (2005:6) asserts that food security has remained precarious and agricultural exports continue to decline as imputes shortages and loss of farm production grew resulting in severe poverty among the people. The land reform program, coupled with the frequent droughts, between 1.5 to 5 million people in Zimbabwe require food relief every three to five years. Hence, poverty becomes predominant given that 70% of the Zimbabwean population resides in the rural areas. Johnston (1998:25) reiterates that highly unequal distribution of land and assets has meant that, the poor have been less able to take advantage of the benefits of economic liberalization. The drought destroyed rural livestock and depleted household assets, from which many poor households have not recovered. AIDS on its own is contributing to household poverty. Hence poverty has increased the people's vulnerability to opportunistic infections due to poor diet and an increase in transactional sex among women as a survival strategy. All these may have fuelled and sustained the HIV and AIDS pandemic in Zimbabwe.

2.4.2 The Economic Structural Adjustment Programme (ESAP)

Johnston (1998:12) points out that the World Bank has worked closely with the GOZ on its ESAP which included reorientation of expenditures within the social sectors and attempts to improve cost recovery in health. The World Bank has influenced the health sector and health

¹⁰³UNAIDS/WHO (2009:17) asserts that Third Chimurenga was the word used largely by government officials to define the controversial land reform program which started in 2000 to redress the colonial imbalances.

outcomes in Zimbabwe by lending money and through policy advice. Indirectly the bank influenced the health sectors and health outcomes through its macroeconomic policy advice and support for economic reform. Johnston (1998:24) adds that Zimbabweans blame ESAP for deterioration of the health sector, high unemployment, rising prices and increased poverty which all have a direct impact on the evolution of the HIV and AIDS pandemic in Zimbabwe. The deteriorating health sector meant lack of HIV and AIDS treatment, insufficient HIV and AIDS prevention information and inadequate care and counseling of people living with HIV and AIDS. Hence HIV and AIDS became highly stigmatized and discriminated in Zimbabwe due to the negative attitudes people held about those who were HIV positive.

On the other hand, Johnston (1998:24) argues that to assess the role of ESAP, in health and socio-economic trends since it started in 1991 is complicated. In making this case, Johnson asserts that “first Zimbabwe was struck by the worst drought of the century as soon as the program started and secondly, HIV and AIDS is placing a growing toll on health and health care system therefore sorting out the effects of ESAP from drought and AIDS is extremely difficult and made more so by data limitations.” In addition Dambisya (2007:9) eludes that recurrent droughts and the decline in the economy has led to food insecurity in the country. Hence high levels of malnutrition greatly increases the people’s vulnerability to HIV and AIDS infection and fast deterioration of the health of those who were HIV positive as well as the development of opportunistic infections.

On the other hand, Dambisya (2007:9) states that ESAP was followed by the Zimbabwe Programme for Economic and Social Transformation (ZIMPREST 1996-2000).¹⁰⁴ According to Adepoju (2008:6) the cost of ESAP had reduced access to education, health, food and social services by removing subsidies. Hence, this reduced the overall welfare of families particularly the poor. Therefore, the cost recovery strategy ZIMPREST became a burden that is heaviest for

¹⁰⁴ Moyo (2005:6) expands that the Zimbabwe Economic and Social Transformation (ZIMPREST) was designed to restructure public enterprises, reform the financial sector and with a proposed market-oriented land reform sponsored by the International Financial Institution (IFI). But the GOZ contradicted the IFI demands in 1997, by making unbudgeted pension disbursement to disaffected war veterans and by designating about 40% of large scale commercial farms for compulsory land acquisition. ZIMPREST collapsed as the currency crashed losing 74% of its value on 14 November 1997. This led to price-hikes and job losses, followed by riots and serial industrial actions led by the Zimbabwe Congress of Trade Union (ZCTU) which the GOZ forcefully suppressed.

the poor. It calls for families to pay the full cost of health and education at a time when family heads are increasingly jobless or sick due to HIV and AIDS. Parents, unable to pay school fees grudgingly withdrew their children from school. Adepoju (2008:7) laments that, “the cumulative result is that the average Zimbabwean today is probably less well educated, less fed, less well employed and less well paid than in the immediate aftermath of independence.”

Pervasive poverty is therefore at the root of many problems confronting families in Zimbabwe. Poverty is generally concentrated among people with low education, unstable employment or unemployment, low income, poor housing conditions and large families. Literature has widely documented that these conditions have provided fertile ground for the spreading, sustainability and evolution of the HIV and AIDS pandemic in Zimbabwe and the rest of Africa especially in Sub-Sahara¹⁰⁵. On the other hand these same conditions have undermined the social fabric of families, communities and the nation at large to care for people living with HIV and AIDS. UNAIDS/WHO (2009:11) add that more than half of the Zimbabwean population is dependent on food aid and its economy has declined more than 50% since 2000. In this regard, the following section reflects on what could be some political determinants of HIV and AIDS in Zimbabwe which have continued to fuel and sustain the pandemic.

2.5 The political determinants of HIV and AIDS in Zimbabwe

UNAIDS/WHO (2009:17) asserts that collectively Africa alone accounts for nearly 75% of the world’s highest incidence of the HIV and AIDS pandemic. Twenty or fifty years ago, HIV and AIDS was hardly heard of. Today, it has already rolled back modest successes achieved by the third world in healthcare undermining the social fabric of thousands of communities even exceeding war as a threat to the lives of millions of people¹⁰⁶. From the foregoing, it follows that examining the political past of Africa, Sub-Sahara and Zimbabwe may bring insight into how our political past may be linked to the evolution of HIV and AIDS in Zimbabwe.

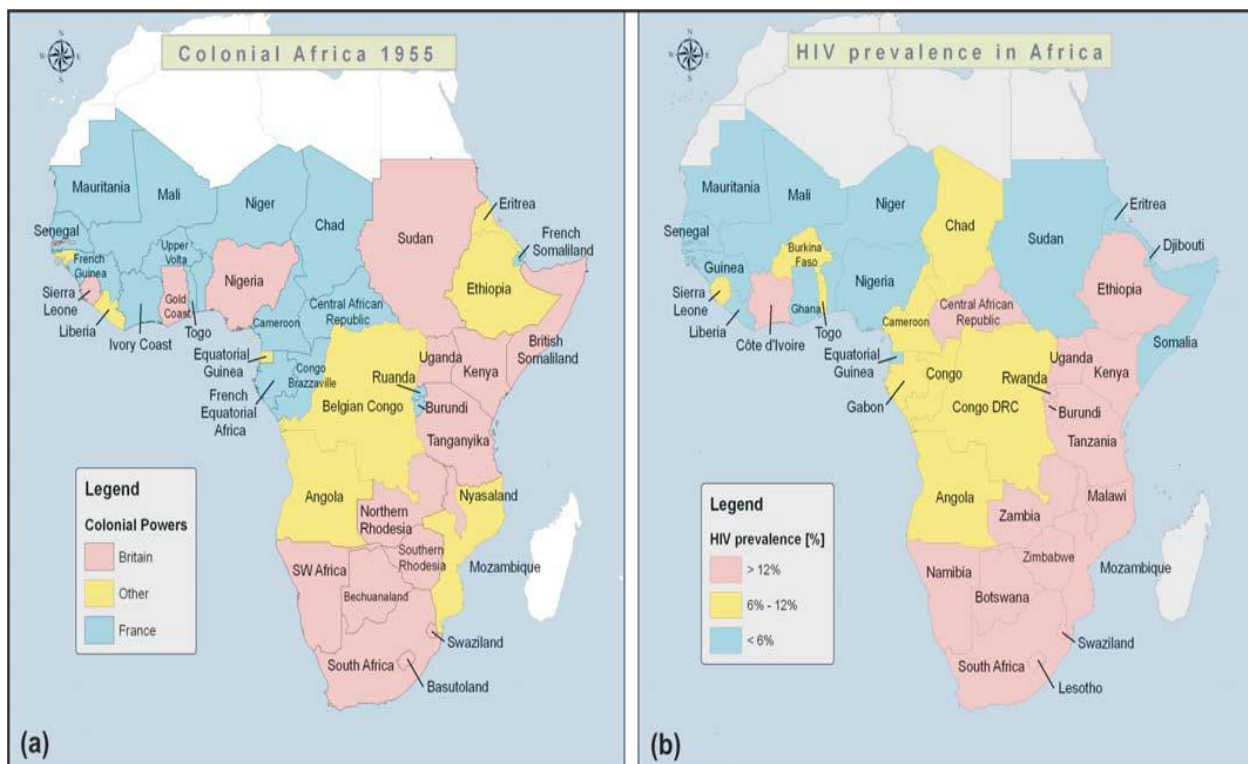
¹⁰⁵Adepoju (2008:7)

¹⁰⁶ Hargrove (2007:3)

2.5.1 The colonial past

Hargrove (2007:3) in trying to highlight why HIV prevalence is highest in Southern Africa in comparison to the rest of Africa and the world uses images in Fig. 2 below, which he describes as very striking and thought provoking. The ex-British colonies have an average peak HIV prevalence level 11 percentage points higher than countries with a different colonial past. What could be the linkage between the colonial past and the high HIV prevalence?

Figure 2: The British colonialism and the HIV epidemic in Southern Africa



Source: Hargrove (2007:3)

According to Hargrove (2007:3) countries of Southern Africa have on average a peak HIV prevalence which is nearly 20 percentage points higher than in the countries of East Africa and nearly 25 percentage points higher than in West and Central Africa. Hargrove points out that ex-British colonies in Southern and East Africa including Zimbabwe are coloured pink (Fig. A) because they constitute eleven of the top fifteen countries in the world in terms of the level at which adult HIV prevalence in urban centres peaked, in their individual epidemic as indicated in

Fig. B. Hargrove (2007:10) argues that, the essential structural elements that predispose Southern Africa to disastrous levels of HIV infection and other social ills are likely to remain largely intact for the foreseeable future. Then the question is, can there be any ray of light in what is now the epicenter of the pandemic?

The linkages between migration and health concerns have only recently been brought to light by the spread of diseases like, TB, malaria and HIV and AIDS¹⁰⁷. Migrants' conditions and restricted access to health services make them especially susceptible to health services. Seasonal migrant workers in particular are vulnerable to and capable of spreading diseases both during and after migration. The role the movement of people has played in the spread of HIV is that, there is a tendency to demonize truck drivers and commercial sex workers. Although it can be acknowledged that roads and road transport played a role in the spread of HIV, Hargrove (2007:8) in making a case about the ex British colonies, argues that it is not roads we should be thinking of. Rather we should be thinking of Rhodes because "it was Cecil John Rhodes, Alfred Beit and their mining associates, aided and abetted by Lord Alfred Milner, who sowed the seeds of the Southern African HIV epidemic and many other problems that are essentially sociological in nature." In support of this argument, Hargrove (2007:8) adds,

The subsequent explosive expansion of the gold fields led to massive development in South Africa which led to further finance for commercial expansion into the neighbouring countries funded largely by Rhodes and Beit. Since the gold was discovered to be deep underground, making it more expensive to mine, hence the demand for labour was huge but all costs had to be kept to a minimum" As the South African mines needed manpower from neighbouring countries, only males could be housed on the mine cite excluding their families. Strong and virile young men from Southern Rhodesia (now Zimbabwe), Northern Rhodesia (Zambia), Nyasaland (Malawi) Mozambique, South West Africa , Swaziland and Basutoland (Lesotho) were recruited and their wives and girlfriends were at home all over Southern Africa and saw each other perhaps once a year.

In order to keep these men on the mining cites, the mine authorities introduced prostitution by bringing single black women onto the mines in order to stabilize African male labour's sexual

¹⁰⁷ Adepoju (2008:12)

outlet and capitalism benefitted from the moral degradation of African women¹⁰⁸. Hargrove (2007:9) asks, “and what of their wives and girlfriends left at home for months at a time?” His answer is, “it was a catastrophe waiting for something like an HIV virus to come along.”. Hargrove (2007:9) adds “what became the norm all over the British colonies was having males only living and working on the mines as well as on farms and plantations, even as domestic workers in big cities. And the pattern was the same everywhere from the Cape through the Rhodesians, Tanganyika and to the white Highlands of Kenya. In cities, in Southern Rhodesia (Zimbabwe), up into the 1960’s, it was illegal for a (white) employer to allow his (black) manservant to have his wife living on the premises with him. This pattern of family disintegration is still prevalent in Zimbabwe. Most Zimbabweans maintain two homes, one in town where usually the husband works and another home in the rural areas, where the wife and children live. This type of setup for a husband and wife is a recipe for HIV and AIDS. In support of this argument Sanders and Sambo (1991:158) argue that “the migrant system of labor in Southern and East African countries contributes to family separation and the spread of diseases (including AIDS) from urban to rural areas as well as in the opposite direction.”

There is need therefore to address urgently the issue of how we can rebuild family structures in Zimbabwe. Hence family structure and factors which impact on the family structure may provide important keys to an understanding of the distribution and evolution of HIV and AIDS in Africa. Hargrove (2007:14) points out that none of the HIV interventions address the fundamental social problems which have ensured that the HIV epidemic would be severe in the Southern African region. Adepoju (2008:15) agrees that the centrality of the family as the focal point of people centred development, should be recognized. Hargrove (2007:15) adds, “AIDS in Southern Africa should be seen not only as a disease but also as a symptom of social ills in general and of the fragmentation and breakdown of family structure in the region.” However, from the foregoing, amidst all social, economical and political turmoil, the HIV prevalence of Zimbabwe is declining. What could have contributed to this remarkable decline?

¹⁰⁸ Vambe (2007:224)

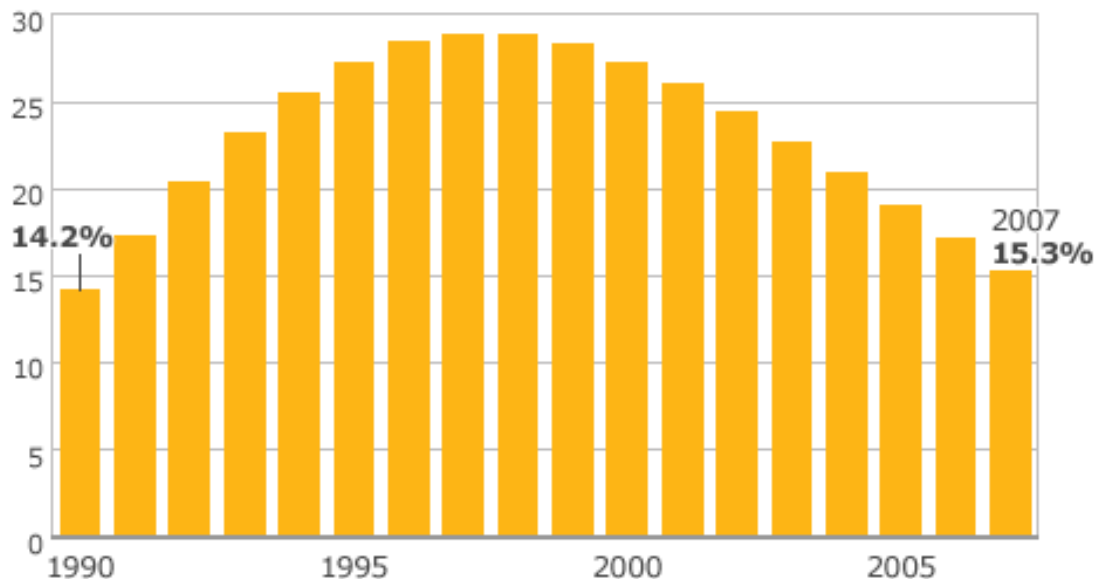
2.6 The HIV Prevalence in Zimbabwe

According to O'Brien (2009:1) in October 2007, the United Nations Country Team (UNCT) in Zimbabwe announced that the decline in HIV prevalence in Zimbabwe was one of the most significant and rapid declines of any country in the world. Whiteside (2008:17-19) a year earlier had noted that the HIV prevalence rate had fallen from 25,7% in 2002 to 17,7% in 2006 representing a decrease of at least 8% in five years placing Zimbabwe's HIV prevalence rate amongst the lowest in the region. MOHCW (2004:57-58) argues that this indicated that Zimbabwe, despite its ongoing political, social and economic crises was seemingly leading the way in dealing with the HIV pandemic that is severely impacting on the health and well being of the people.¹⁰⁹ The graph below (Graph 1) clearly indicates how the prevalence of HIV has declined over the years.

¹⁰⁹Mahomva et al in Hargrove (2007:9) ascertain that, "despite all the economic, social, legal shambles in Zimbabwe, HIV prevalence among women attending antenatal Clinic (ANCs) in Harare has been declining at nearly 10% per annum since about 1998."

Graph1: The prevalence of HIV in Zimbabwe**Prevalence of HIV**

% of population, 15 to 49-year-olds



Source: World BankSource:

World Bank (2010:3)

2.6.1 Sources of data for the estimate of HIV prevalence in Zimbabwe

MOCHW (2007:122) states that the main source of data for estimating HIV prevalence is through pregnant women who visit Ante Natal Care (ANC). This data is then used to generate estimates of HIV prevalence for 15 to 49 year olds in the country as a whole (MOCHW 2004:6-7). O'Brien (2009:1) adds that the other main source of data for estimating HIV prevalence is population-based surveys and anonymous voluntary blood samples were taken to check for HIV status. Other sources mainly for correlating, sentinel and population based surveys are anonymous data from Voluntary Counseling and Testing Centres where people visit. (For a discussion on how ANC testing is carried out in Zimbabwe see (MOCHW 2004:67).

2.6.2 National and International responses to the HIV prevalence decline in Zimbabwe

Responses to the decline in HIV prevalence in Zimbabwe were varied and relatively low despite the potential importance of the statistics which were accurate. O'Brien (2009: 3) argues that

global media outlets were less than enthused with media reports from Zimbabwe which potentially put President Robert Mugabe in a positive light. Whiteside (2008:18) adds that persistent doubts were expressed about the reliability of the data in a country undergoing political and economic collapse. However, among members of the Zimbabwe Government there was more enthusiasm for the decline. Gore in O'Brien (2009:3) asserts that, in July 2003, the then Zimbabwe Minister of Health Dr. David Parirenyatwa utilized the backdrop of the Southern African Development Community (SADC) Summit on HIV and AIDS in Lesotho to claim that, the prevalence rate had fallen from 33% in 2000 to 30% in 2001 to 24,4% in 2003. The Minister further claimed another epidemiological breakthrough that Zimbabwe was the first African country to have used the sophisticated Epidemic Projection Package computer software to analyze the ANC data and other data to generate its national estimates. O'Brien (2009:3) points out that President Robert Mugabe in His speech at the Zimbabwe National HIV and AIDS conference in June 2004, asserted that HIV prevalence rates had plateaued at around 24.6%.

In the same vein, O'Brien (2009:3) stipulates that UNAIDS/Zimbabwe assembled a team of epidemiologists and HIV experts including representatives of organizations such as the US Centres for Disease Control, UN agencies, the Zimbabwe Health of Ministry, bilateral donors, British Department of Foreign Development (DFID) and the USAIDS to assess all available data. One of their conclusions was that, the decline in national HIV prevalence between 2000 and 2004 has been falling by 10% over the past five years and is currently reported as 15%. The burning question is, who takes the credit for the declining HIV prevalence rate?

2.6.3 Who takes the credit for the decline of the HIV prevalence in Zimbabwe?

O'Brien (2009:4) points out that the Ambassador of the United States (US) to Zimbabwe, McGee James, in a ceremony acknowledging individuals who had contributed to breaking down AIDS related stigma and discrimination, asserted that the success of the US and Zimbabwe collaboration in AIDS programming was evidenced by the decline in the HIV prevalence. A year later McGee, on the same occasion directly stated that the remarkable decrease in adult HIV prevalence from 19,4% in 2005 to 15, and 3% in 2007 demonstrated the effectiveness of US supported prevention efforts.

O'Brien (2009:4) adds that in the same vein, a DFID web page announced that its consistent support to HIV and AIDS prevention programmes over the last decade has helped contribute to the decline in the numbers of people living with AIDS in Zimbabwe. DFID according to O'Brien also mentioned that Zimbabwe was on track to achieve the Millennium Development Goals (MDG). Hallet et al in Hargrove (2007:11) is of the opinion that those declines could not be attributed solely to the direct effects of increased deaths among HIV positive individuals, but were associated with declines in HIV incidences and changes in sexual behavior. Hargrove (2007:11) points out that this view has been met with great skepticism from some scientists.

On the other hand, Hargrove (2007:12) suggests that, "perhaps simple intelligence, rather than efforts of government and AIDS agencies, is the most important factor underlying the decline in HIV prevalence seen not only in Harare Zimbabwe but also in Uganda." Community self organization for example, can be seen as more significant than any conscious policy by the Ugandan government in combating AIDS. Epstein (2007:136) agrees with this view and emphasizes the importance of Uganda's social cohesion in achieving behavior change and partner reduction. However, O'Brien (2009:10) and Kalhorn (2011:7) agree that other factors are at play in Southern Africa, which makes the epidemic different to Uganda. Karlhorn (2011:13) is therefore convinced that what may work in one country may not necessarily work in another. Paroske (2009: 157) quotes President Mbeki in His address at the Durban Conference in 2000 as He pointed out the importance of understanding different context in which HIV is embedded,

We will not eschew this obligation in favour of the import of the recitation of a catechism that may very well be a correct response to the specific manifestation of AIDS in the West. We will not ourselves condemn our own people to death by giving up the search for specific and targeted help.

HIV and AIDS, as a sexually transmitted disease, is widely accepted that sexual behavioral change is needed to lower HIV prevalence rates. The behavior change paradigm assumes that, people have the ability to change their behavior at will, ignoring many factors that limit people's behavior and choices. However, according to Dambisya (2007:8) the dilemmas behavioral change prescriptions pose for women in Africa, are rarely considered. The possibility that the 'safe sex' message may be quite unsafe for millions of women, is all too frequently overlooked.

Dambisya adds that according to the Behavior Change Strategy, married women are particularly vulnerable to infection, hence the need to be highlight this in future intervention programmes.¹¹⁰

UNAIDS (2005:9) cites a number of studies where women had been infected despite staying faithful to one partner. UNAIDS/WHO (2004:10) record that, in many cases the main HIV risk factor for a woman is the fact that she is faithful to a husband with previous or current other sex partners. This effectively eliminates the efficacy of monogamy as an AIDS prevention strategy for women in Sub-Sahara Africa¹¹¹. Hence behavior change strategies cannot take all the credit for the decline in the HIV prevalence in Zimbabwe.

The evidence of the declining HIV prevalence rate in relation to the effectiveness of condom programmes in Zimbabwe is unclear. AIDS prevention discourse has paid little attention to the needs of the majority of women whose risk derives from sex with their husbands. The sexual double standards which form an integral part of the rules of heterosexuality in many Sub-Sahara African cultures give men sexual license whilst female sexuality is restricted (2.4.2).

Sanders (1990:8) articulate that, in as far as education contributes to better health behavior; Zimbabwe's phenomenal post-independence expansion in school enrolment is highly significant. The number of schools grew from about 900 000 in 1979 to 2,7million in 1988 an average annual increase of over 20%. In this regard, Sanders comments that the impact that this has on health is likely to show up only in the long run. Hence, it is uncertain to what extend the rate of formal education of the people of Zimbabwe has contributed to the decline in the HIV prevalence rate in Zimbabwe.

Interestingly, O'Brien (2009:11) is of the opinion that, the actual reduction in the HIV prevalence is something which we have a limited capability to assert. However, we can observe, even from far how it has been used as a devise of propaganda in both national and international forums, in the ongoing conflict between elements of the Zimbabwean State and the West. O'Brien (2009:12) adds, "maybe justifiable suspicion of figures is perhaps what partly lies between the MDC's unwillingness to accept the reported prevalence decline." The MDC's (2007:168) manifesto disputed the new figures stating that,

¹¹⁰ UNAIDS/WHO 2004:28) is of the view that for married women being faithful to one partner does not protect them against infection rather "they run the risk of being infected by that partner."

¹¹¹ Elias and Heise (1993:15).

The incidence of HIV infections is assumed to be unchanged at 25% of the adult population. Recent reductions in infection rates are thought to be based on inadequate information and are deemed unreliable.

On the other hand, O'Brien (2009:12) highlights that all the AIDS related data gathering techniques used in reports are extremely useful information for understanding the AIDS epidemic. However, O'Brien (2009:12) argues that they miss out on the people and their lived experiences. People's individual voices become lost as individual responses about stigma, bereavement, physical pain and the daily struggles to survive become transfigured into numbers. Human lives, emotions and experiences are lost among mortality figures, HIV prevalence and incidence rates. In the same vein earlier on, Whiteside (2008:87) had noted that while numbers matter for funders, they do dehumanize the people they claim to serve.

From the fore going, Hargrove (2007:12) laments that the present levels of HIV infection are still entirely unacceptable even in Zimbabwe where it appears to be declining rapidly for six years. This is further supported by Mpofu and Nyahoda (2008:5) and UNAIDS/WHO (2009:12) who add that despite the promising news, new HIV infection rates remain unacceptably high and women and girls continue to be particularly vulnerable. According to the preliminary results of the Zimbabwe Demographic and Health Survey (ZDHS) (2007), 21% of women are HIV positive, while 15% of men are HIV positive. Hence with everyone taking the credit for the decline in HIV prevalence in Zimbabwe, it becomes imperative to examine how the Government of Zimbabwe (GOZ) has responded to the HIV pandemic.

2.7 National response to the HIV and AIDS pandemic

The initial years of the HIV and AIDS epidemic, the GOZ forwardly accepted the existence of AIDS but in reality denied it was an issue¹¹². The first recorded death occurred in 1985, blood screening was intensified and the National AIDS Control Programme (NACP) was formed and the emergency plan was implemented in 1987. Gundani and Rodlach in O'Brien (2009:5) agree that despite this high level of acknowledgement, the GOZ continued to shroud the epidemic in secrecy and concealment.

¹¹²UNAIDS (2006:7)

2.7.1 Initial Response

By 1989, Zimbabwe's HIV prevalence of 10% was among the highest in the world prompting President Robert Mugabe to announce in 1990 that Zimbabwe was in great jeopardy. The Ministry of Health and Child Welfare (MOHCW) medicalised the AIDS response by focusing on infection control and treatment, rather than on addressing the social, economical and political conditions which created vulnerability as discussed above (2.4). According to Renfrew in O'Brien (2009:5), this change in attitude coincided with the implementation of the ESAP in the early 1990's which reduced investment in education and health (2.5.2). O'Brien adds that the GOZ's development and function of coordination mechanisms, the need for a more considered response, and acceptance of the National HIV policy strategic framework, AIDS levy and National AIDS Action Council (NAAC) in the period 1997 to 2000 indicates acceptance of the need for a more considered response. What follows is a discussion of how NAAC was developed and how it operates in responding to the HIV and AIDS pandemic in Zimbabwe.

2.7.2 The Zimbabwe National AIDS Action Council (NAAC)

In 2000, after a series of interim plans addressing short-term goals, the parliament of Zimbabwe created the National AIDS Action Council (NAAC), adopted the National Strategic framework on HIV and AIDS and imposed a levy to help address the AIDS crisis¹¹³. The NAAC under the auspices of the MOHCW includes representatives from the GOZ, NGO, FBO, the private sector and the media and the Zimbabwe National Policy on HIV and AIDS has guided the country's response since 1999. Mpofu and Nyahoda (2008:16) point out that the NAAC programme has eight theme areas with regard to HIV and AIDS which are, prevention, care, mitigation, advocacy, monitoring and evaluation with research and care receiving the highest NAAC budget.

The NAAC in Zimbabwe was established in 1999 by the National AIDS Council Act, No.14 of 2000 to co-ordinate, facilitate, mobilize, support and monitor a decentralized national multisectoral response to HIV and AIDS, in accordance with the Zimbabwe Strategic Framework for HIV and AIDS interventions (2000-2004)¹¹⁴. The NAAC is tasked with the

¹¹³Gwemende (2010:10)

¹¹⁴ Mpofu and Nyahonda (2008:3)

statutory responsibility of administering the National AIDS Trust Fund (NATF) which collects a levy of 3% of taxable income from every individual and corporate tax payer, hence referred to as the AIDS levy. Zimbabwe has accepted the concept of a single national AIDS strategy, a single national AIDS monitoring and evaluation system and is putting much energy into making these concepts a reality. Literature has well documented demoralizing stories about how the AIDS policy was overshadowed by competing political priorities, undermined by institutional inadequacies and insufficient funding, plagued by high level scandals. In line with the objectives of the policy the GOZ called for a multisectoral approach to AIDS, presupposing more effective coordination and funding of HIV programmes, including increased international support and a strategy in which stakeholders are supposed to play a synergetic role¹¹⁵.

2.7.3 The Multi-sectoral approach to AIDS in Zimbabwe

With regards to the multi-sectoral approach to AIDS, O'Brien (2009:7) observes that this approach coincided with a period of political instability and economic meltdown in 1997. This was followed by the fiasco for the land reform and the emergence of new political actors, which contested President Robert Mugabe in the elections of 2000. Fourie (2006:174) refers to these as 'structural impediments in the formation and implementation of the AIDS policy.' However, the international community has mobilized to fight the HIV and AIDS epidemic in Africa on several fronts involving international organizations, Non-Governmental Organizations (NGO), industry and governments. Key players include UNAIDS, the leading advocates for global action on HIV and AIDS formed in 1995 which brings together seven UN agencies in a common effort to fight the epidemic, the UN Children's Fund (UNICEF), the UN Development Programme (UNDP), the UN Population Fund, (UNFPA) the UN International Drug Control Programme, (UNDCP), the UN Educational Scientific and Cultural organization (UNESCO), the World Health Organization (WHO) and the World Bank.¹ IPI (2000:6) report states that since 1987, the WHO has provided financial support and technical guidance for AIDS activities in more than 150 developing countries and Zimbabwe is one of them. On 31 December 1995 the program was reformed as the UNAIDS. The same report elaborates that to ensure the continuity of its response to HIV and

¹¹⁵ UNAIDS (2006:v)

AIDS global needs, WHO established the office of HIV and AIDS and Sexually Transmitted Infections (STIs).

O'Brien (2009:8) asserts that as the past 1999 political and economic crisis progressively unraveled in Zimbabwe, the international donors withdrew funding or channeled development assistance through means other than the state. In the same vein, Moyo and Yeros (2007:185) and Shamu et al (2010:13) highlight that post 2000 donors shifted to direct payment to NGOs and other non state actors now governed by the Private Voluntary Organization (PVO) Act Chapter 17/05 of 2007. In other words, overall AIDS funding to Zimbabwe decreased and Zimbabwe continues to be the least funded national programme by the Global Fund, despite having the fourth highest infection rate in the world. O'Brien (2009:8) adds that President Mugabe in his televised address on the eve of World AIDS Day in 2004 claimed that 'despite these international colonial onslaughts, Zimbabwe had used its 'own internal resources and structures to fight and record measurable progress against the pandemic.' These indigenous measures referred to the AIDS levy which imposed a 3% levy on all Pay As You Earn tax payers, which went towards a National trust Fund (NTF) administered by the NAAC.¹¹⁶

In the midst of all this, O'Brien (2009:8) states that external support remains the largest funding source for AIDS related programmes, although Zimbabwe is not one of the fifteen countries prioritized by the US President's Emergency Plan For AIDS Relief (PEPFAR). In comparison, O'Brien (2009:8) points out that, the NTF fund through the AIDS levy, collected only US\$10 million in 2005 and the sources of external funding were US\$74, 884, 345 from bilateral donors of which US provided US\$24million and Britain were the major donors US\$18,952,762, from the UN and US\$ 9,215,366 from international NGOs. These monies were directed through local and international NGOs instead of the GOZ's ministries. There are over 400 AIDS service NGOs in Zimbabwe affiliated to the Zimbabwe AIDS Network (ZAN) and the GOZ brought in legislation which regulated how NGOs received and spent donor money in Zimbabwe. Despite all these organizations internationally and locally assisting in fighting the pandemic, the gravity

¹¹⁶According to Price-Smith and Paly (2004:34) the NTF and the NAAC were dogged by accusations of misappropriation and bureaucratic ineffectiveness

of the epidemic in a poor country like Zimbabwe necessitated the country to declare a state of emergence in 2002.

2.7.3.1 The battle cry

In 2002, the GOZ declared a state of emergency to fast track the provision of ARVs and this allowed the importation of raw materials to manufacture ARVs locally¹¹⁷. Although this was permitted under World Trade Organization regulations it was not clear if WHO qualified standards would be met. Musuka (2005:8) affirms that Dr. D. Parirenyatwa asserted that the GOZ licensed local companies to manufacture ARVs. GOZ is supporting these local companies through provision of foreign currency to import the inputs required for the manufacturing of these drugs.

Concerning the issue of ARVs in Zimbabwe, Dongozi in O'Brien (2009:9) points out that, at times the supply of ARVs to those already on treatment nearly ran out at the end of 2005 and became inaccessible in some areas. Sollom (2009:4) articulates that in 2005 AIDS activists accused the GOZ of favoritism and nepotism by administering scarce and expensive ARVs to the well connected. Meldrum (2004:183) cites rumors that MDC supporters have less chance of accessing ARVs than do ZANU PF supporters in Zimbabwe.

GOZ (2008:5) affirms that despite the GOZ's aim to massively rollout ARV drugs to people who needed them, it fell far short of its plan to provide ARV services to 250,000 people living with AIDS by December 2007. International donors stepped in, to become the major providers thereby lessening government influence over their allocation and related funding mechanisms¹¹⁸. By 2009, it was believed that 205,000 people were enrolled on ARV programmes but some 500,000 still required the ARVs." In trying all these efforts to mitigate the impact of HIV and AIDS on people, the National HIV and AIDS policy became important.

2.7.4 Zimbabwe National HIV and AIDS Policy (ZNHAP)

According to the USAID/Zimbabwe HIV and AIDS Strategy (2003:11), in 1999, the NAAC finalized two important policy documents to guide the national response to the pandemic with

¹¹⁷ Gwemende (2010:22)

¹¹⁸ O'Brien (2009.9)

the support from USAID which are, *The National Policy on HIV and AIDS for Zimbabwe and the Strategic Framework for a National Response to HIV and AIDS*. The Zimbabwe National HIV and AIDS Policy (ZNHAP) for Zimbabwe is a comprehensive document that addresses all critical issues in the fight against AIDS. It has been widely disseminated through Zimbabwe and most of those working in the field are familiar with it. The ZNHAP was developed in order to promote and guide present and future responses to AIDS in Zimbabwe.

In the National Policy on HIV and AIDS for Zimbabwe (1999) Guiding Principle Two, stipulates that because of the stigma still attached to HIV and AIDS, the rights of people living with HIV and AIDS need special consideration hence providing care and counselling is essential in order to minimize the personal and social impact of HIV and AIDS. In Zimbabwe the care of people living with HIV and AIDS is integrated into the Primary Health Care (PHC) delivery system. It is clear that the PHC delivery system is strained by the increasing problem of HIV and AIDS. Hence in the Zimbabwe National Policy on HIV and AIDS (1999) Article 5 entitled, Care for People Living with HIV and AIDS states;

The needs of individuals with HIV and AIDS, their families and communities pose a serious challenge to the health care delivery and social welfare system. A holistic approach to care should address the physical, psychological and social needs of people with HIV and AIDS and their families. People affected by HIV and AIDS should be treated with respect and dignity; Health professionals and others providing care should be sensitive to the diverse needs of PLHWA and their families.

Furthermore, the ZNHAP (1999) Article 5:3 states,

Counselling is acknowledged as a vital component of HIV and AIDS prevention and care. HIV counselling is stipulated as having two main functions that are often interrelated. Firstly, it is to offer psychological and social support to enable those infected and affected by HIV to deal with a wide range of emotional, social, economic and medical problems. The diagnosis of HIV infection or the realization that one has been exposed to HIV infection has emotional, social and medical consequences.

The second function of counselling is to enable the concerned persons prevent HIV infection by assessing and understanding risky life styles and define their potential for behavior change.

The above policy states that the first function of HIV and AIDS counselling is to offer psychological and social support to people living with HIV and AIDS. It also indicates that getting to know one's HIV status has emotional, social and medical consequences. What I observed is that the HIV and AIDS policy in terms of a holistic approach to the care of people living with HIV and AIDS is silent about the spiritual needs of people living with HIV and AIDS. The discussion in this chapter so far has clearly indicated that HIV and AIDS is more than a sexually transmitted disease. HIV and AIDS is also a disease of society. Hence it impacts the totality of the person. That means, it has more than medical, emotional, social and psychological consequences. The fact that the policy advocates for a holistic approach to care of persons living with HIV and AIDS raises the expectation that the spiritual needs of people living with HIV and AIDS should also be considered as part of their care within the primary health care delivery system in Zimbabwe. This strange silence about the spiritual needs of persons living with HIV and AIDS within a holistic approach to their care, intrigued my interest as this stood out to be a missing gap which calls for research. I became interested to explore and establish that people living with HIV and AIDS have spiritual problems and needs which should be cared for within the primary health care delivery system. I became interested in also exploring, how the spiritual problems and needs of people living with HIV and AIDS can be addressed within the primary health care delivery. What follows is a discussion on the PHC delivery system in Zimbabwe, how it operates and how the care of people living with HIV and AIDS is integrated into the PHC.

2.8 The primary health care delivery system in Zimbabwe (PHC)

After independence the GOZ sought to address the imbalances of the past by providing integrated health services which were development oriented based on the principles of acceptability, affordability, accessibility and appropriateness of health services¹¹⁹. The GOZ adopted the PHC policy at independence, in an endeavor to achieve equity and better quality of services, more affordable, accessible and appropriate to the needs of the majority of the

¹¹⁹ Johnston (1998: 14)

people¹²⁰. The post-independence development rapidly improved the health sector for the majority of the people from less than 60% in 1980 to greater than 80% by 1990¹²¹. Shamu et al (2010) add that, three waves of social economic developments shaped the health sector in Zimbabwe; a period of high public expenditure (1980-1990); followed by liberalization and provision (1990-2000); and the current economic downturn (2000 to present). The later period has also seen severe depletion of the health sector, human resources as professionals and personnel leave the country for better paying economies in the region and overseas. Hence in what follows I discuss these three waves of socio economic developments and how they shaped the PHC in Zimbabwe and the service delivery to the patients.

2.8.1 Post Independence (1980-1990) and the PHC

The Zimbabwe post independent health policy reflected the broader national objectives outlined in the Transitional National Development Plan, which stated, “to establish a society founded on socialist, democratic and egalitarian principles and to end imperialist exploitation through more equitable Zimbabwean ownership of the means of production¹²²”. This health system was envisaged as integrally linked to other developmental programmes such as the organization of rural infrastructure, education, housing and food production. The priority task in 1980 was stated to be the restoration and rehabilitation of the war torn infrastructure. The adoption of the Primary Health Care (PHC) approach demanded the direction of the new resources towards previously deprived areas in the improvement of nutrition and the control of preventable diseases¹²³. The policy stressed the conscious and active participation of communities in transforming their own health. Johnston (1998:17) asserts that with the expressed recognition that the causes of ill-health lay in the conditions of people’s lives and in the context of an urban racially and curatively biased health care system, the government in 1980 guaranteed to transform health care so that all citizens would have access to a comprehensive integrated National Health Service.

Sanders (1990:10) points out that in line with the new PHC approach, the management and delivery of care has been slowly transformed and some of the changes introduced since

¹²⁰Sanders (1990:7)

¹²¹ Dambisya (2007:15) and Shamu (2010:7)

¹²² Sanders (1990:8) and Dambisya (2007:15)

¹²³Sanders (1990:9)

independence are, free health care, hospital and rural health care building programme¹²⁴. Zimbabwe expanded programmes in immunization, diarrhea, disease control programme, national nutrition programme and child spacing. All these and other programmes required expansion in government expenditure which grew substantially after independence. On the other hand Kaseke (1998: 22) adds that the PHC policy emphasizes preventive services, reflecting the changing philosophy of the government. According to Kaseke (1998:22) health policies were based on racial segregation during the colonial period and because they were designed primarily for the benefit of the white settlers, there was an urban bias in their provision. The neglect of rural areas by the colonial government forced missionaries to take corrective measures thereby assuming greater responsibility for the provision of health services in rural areas.

2.8.2 Liberalization and provision (1990-2000)

The Zimbabwe health care system is highly liberated. The state sector operates alongside private for profit operators in urban areas and church based health care in rural areas¹²⁵. However, the state sector largely serves the lower income urban and rural population with higher health needs. After independence the new majority government embarked upon extensive investment in social services and resources were deployed towards the provision of universal education and health care. GOZ focused on improving access to services for the marginalized black population and targeted the rural communities. Shamu et al (2010:8) add that, the strategy was cemented in the 'Growth Points' policy of building 'urban centres' in rural areas. These centres were designed to provide a complete package of services and were also designed to be the major health centres for the rural population. The centres were provided with a general hospital which also served as the base from which, outreach health services were delivered to the remote rural hinterlands.

Accordingly, Sanders (1990:14) points out that a central feature of the PHC approach is democratization, a process essential to genuine community participation with both sides benefitting. Hence community health workers (VHW) programmes, which are democratically controlled by the poor majority, can serve the function not only of extending health care to even

¹²⁴Johnston (1998:17)

¹²⁵ Shamu et al (2010:12)

isolated communities, but also of mobilizing people to transform their living conditions and thus their health.

On the other hand Johnston (1998:17) points out that by early 1990's the adult HIV prevalence rate had already reached 10% in Zimbabwe but political leaders resisted acknowledging the extent of the AIDS pandemic. Hence, the GOZ started preparing with the World Bank and IMF for the ESAP that was launched in 1991. According to Johnston (1998:17) the GOZ and the World Bank initially thought that ESAP would bring increased growth and that, the social sectors and the poor would be protected. Johnston is of the opinion that this proved to be false hope. Private provision of health services increased and expanded rapidly in the 1990s, contributing to staff shortage in the government health sector. With the MOHCW's request, AIDS prevention was done under a new project STI, which responded to the AIDS epidemic under a critical shortage of government funds for drug procurement.

2.8.3 The economic downturn (2000 to date) and the PHC

Zimbabwe has consequently suffered from the brain drain phenomenon, particularly in the area of health, due to the economic decline in the country and the resultant of health workers worsened from 2000¹²⁶. Many health care centres are therefore being manned by demotivated, frustrated and poorly paid staff whose major preoccupation is how to make more money¹²⁷. Long quos of patients and clients characterize health centres. Kaseke et al (1998:28) add that, there is an inadequate number of ambulances resulting in some patients not getting treatment on time especially in the rural areas. According to Moyo et al (2008:41) the Zimbabwe Association of Doctors for Human rights (ZADHR) confirmed that the country's health care system is in need of urgent attention. It is crippled by dilapidated infrastructure, drug shortages, equipment breakdown, brain drain and health care costs that have skyrocketed beyond the reach of many people. From the foregoing, what follows is a discussion of how the PHC as a system operates.

2.9. PHC system in Zimbabwe

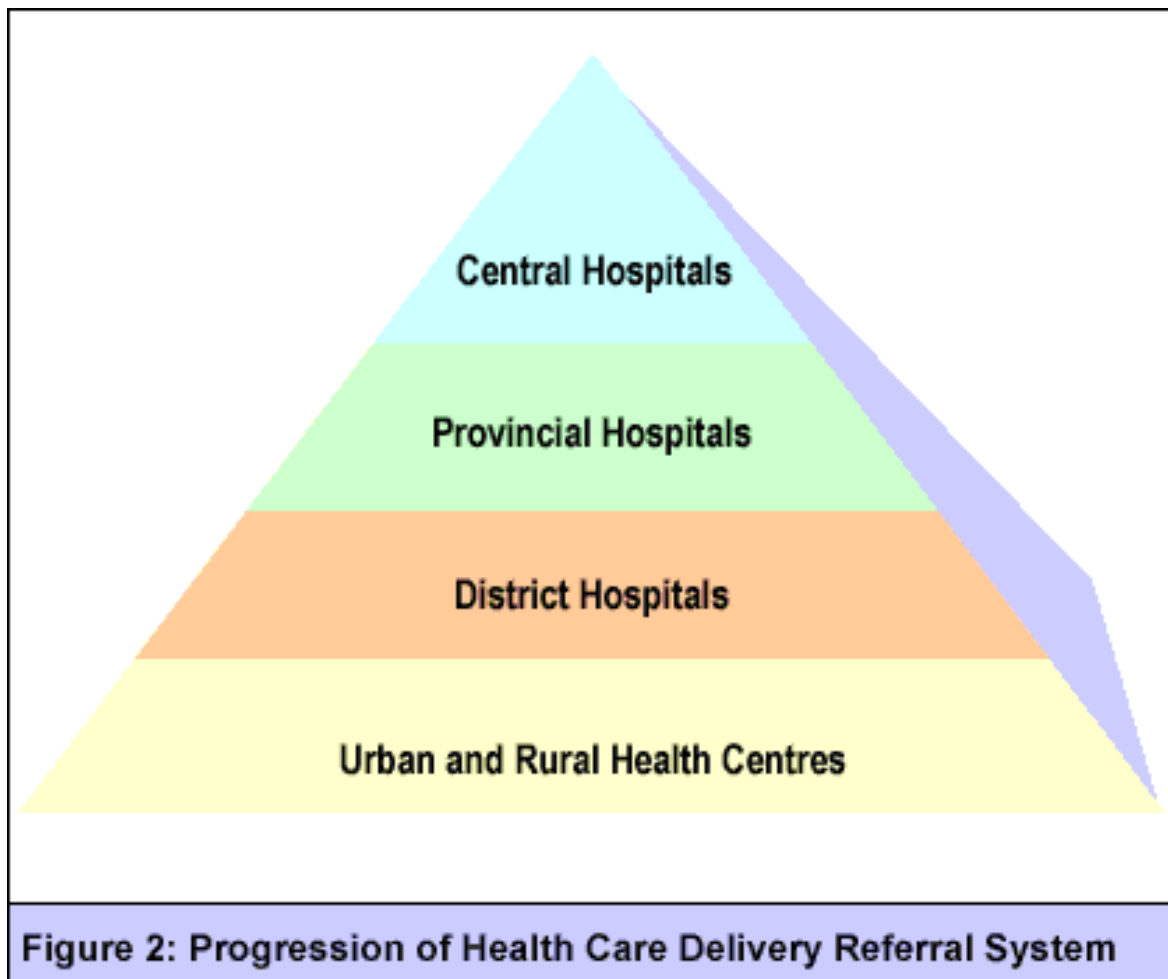
¹²⁶ Adepoju (2008:9),

¹²⁶ Mudyarabikwa and Mbengwa (2009:7)

¹²⁷ Makumbe (2009:2)

The Zimbabwe health system is diverse. Health care is delivered by central government, municipalities, rural district councils, church mission facilities, private providers and traditional healers.¹²⁸ The government of Zimbabwe operates a four tier health system as indicated below in Figure 3.

Figure 3: The progression of the PHC referral system in Zimbabwe



Source: Shamu et al (2010:6)

The entry level into the PHC is made up of rural health centres, rural hospitals and urban clinics. The services do not require an attending physician. The first referral level is made up of district

128 Dambiswa (2007:17)

hospitals. The second referral level is made up of provincial and general hospitals. The third referral level is made up of the central and special hospitals.

The first level consists of nearly 1000 rural health centres half of which are operated by Rural District Councils with others run by the MOHCW, missions, municipalities and industry. At the next level 37 district hospitals and some mission hospitals provide curative care and basic surgery and serve as referral centres for the clinics. The third level consists of seven provincial and five general hospitals that provide some specialist services although in some provinces they are not much better equipped than the district hospitals. Finally, six central hospitals form the top of the referral system. In each district a District Health Executive, headed by the District Medical Officer and a District Nursing provincial Health Executive led by the Provincial Medical Director plans and supervises health services in each province¹²⁹.

2.9.1 The referral process within the PHC

In theory patients are required to present themselves at the entry level facilities first and then, be progressively referred upwards if the condition warrants such a referral¹³⁰. However, the Ministry of Health has admitted that in practice the referral process functions poorly. Conditions of rural health facilities is so poor that people bypass them and self-refer to higher level facilities with the hope to get the care desired. The most basic medical and surgical care is available only in the central and the better general hospitals. It is for this reason that people by pass their local health facilities and put services pressure on large institutions especially the central hospitals¹³¹. The PHC approach is supposed to provide a chain of increasingly sophisticated facilities so that, patients with more complex conditions can be referred up the line. In practice the referral process functions poorly and as such, people by pass their local health facilities and put service pressure on the larger institutions especially the central hospitals¹³². Sanders (1990:13) is of the opinion

¹²⁹ World Bank (2009:13) report

¹³⁰ Shamu et al (2010:6)

¹³¹ Shamu et al (2010:6)

¹³² Sanders (1990:10)

that, despite the government's enthusiastic PHC drive and its stated commitment to equity in health, the referral system appears still to function poorly.¹³³

2.9.2 Health Care Workers within the PHC

Human resources are key determinants of the success or failure of health systems and the performance of health care systems is a function of the availability, know-how, skills mix and motivation of personnel delivery services. Mudyarabikwa and Mbengwa (2006:7) add that, many of the health indicator improvements achieved during the first ten years of independence in Zimbabwe are on the decline. This is due to the shortage of skilled and experienced health care workers at a time when demand for services, is increasing because of the challenges posed by HIV and AIDS.

Accordingly, Mudyarabikwa and Mbengwa (2006:8) state that policies to increase health worker numbers were shelved or abandoned during ESAP in the 1990s. The International Monetary Fund (IMF) and the World Bank did not exempt the health sector from austerity measures that aimed to rationalize the public service. The Public Service Commission (PSC) and not MOHCW employs health care workers which creates disparities in policies that concern distribution of health workers. In practice, MOHCW determines ideal staff requirements to provide minimum health packages but has no power to increase posts beyond the establishment set and approved by the PSC. Mpofu and Nyahoda (2008:17) are of the opinion that, from a number of reasons and for almost all categories of health professional, the PSC approved establishment is lower than the ideal requirements of MOHCW. The PSC approved posts are even lower than the WHO minimum standards specified in the Human Resources Master Plan used by the Ministry.¹³⁴ In health professional groups, the highest loss in Zimbabwe are doctors, nurses and pharmacists although other non-clinical health workers are also affected. In line with this thought, Mpofu and

¹³³ Sanders (1990:13) explains this further by using a study performed in the early 1986 at one district (KAROI) one provincial (Chinhoyi) and two central (Harare and Parirenyatwa) hospitals, data collected illustrated this quite starkly. While 32, 6% of Karoi hospital in patients came from within 10km of the hospital, for Chinhoyi the figure was 37, 6% and for Harare and Parirenyatwa 59, 3% and 56, 2% respectively. Further, 50, 9% of in-patients at Parirenyatwa hospital had used this facility as the first point of contact. The corresponding figures for Harare were 11% and a staggering 67, 7% who used this "quaternary" facility as their second place of contact with the health service.

¹³⁴ Mudyarabikwa and Mbengwa (2006:3) assert that the public sector provides as much as 65% of health care services in Zimbabwe and so a shortage of public sector health workers affects a great majority of the population.

Nyahoda (2008:17) point out that the major causes of these losses among the health workforce are reportedly poor benefits and professional problems, such as the lack of resources and facilities, heavy workloads and insufficient opportunities for promotion and self-movement. Mudyarabikwa and Mbengwa (2009:7) have observed that, despite having provision for more staff, the urban public facilities are still notorious for congestion and delayed services for patients because not all posts are filled.

2.9.3 PHC and Zimbabwe Traditional Healers

Kaseke (1998:25) states that in the area of health, the GOZ recognized that most of the African people utilized traditional healers and it sought to acknowledge the contribution of traditional medicine, by enacting the traditional medical practitioners Act of 1981. Dambisya (2007:16) acknowledges that Zimbabwe has a full-fledged traditional health system that exists. Shamu et al (2010:9) contends that a sizeable portion of Zimbabweans make use of these services on a fee basis. Evidence of this is the National Health Accounts Report quoted by Shamu et al (2010:9) which shows that 3% of the sampled population sought the services of traditional healers in 1999 and 7,4% sought the services of faith healers, with 88,5% paying fees for services of traditional healers and 57,6% for services of faith healers.¹³⁵ Kaseke (1998:25) is of the opinion that the incorporation of traditional mid-wives in the health delivery system is reflective of cultural considerations which must also be considered in a holistic approach to the care of patients.

2.9.3 The integration of HIV and AIDS into the PHC in Zimbabwe

Dambisya (2009:21) consents that, some countries like Zimbabwe have adopted a public health care approach known as the Primary Health Care (PHC) approach to HIV and AIDS services delivery. Dambisya (2009:21) asserts that many components of the PHC approach as defined by WHO are, the use of appropriate mechanisms to ensure consistency and quality of the national

¹³⁵Although the Zimbabwe National Healers Association (ZINATHA) was formed after independence, ZINATHA responded to the mitigating process on the people of Zimbabwe as early as 1988 as reported by Terry (2006:83). At that time, according to Terry 1500 traditional healers out of 50 000 attended healers HIV and AIDS workshops organized by NAAC leaving a large gap in information dissemination. Terry, (2006:83) declares that by 2006 there were 52 500 traditional healers registered with ZINATHA compared to 2000 Western trained physicians in Zimbabwe.

supply of HIV related drugs and diagnosis and their equitable and rational use; simplification of treatment using standard treatment protocols/guidelines and simplified clinical monitoring procedures; team based approach to patient management and delegation of care aspects of patient follow-up to trained nurses and community workers; increasing knowledge of HIV status through the use of rapid testing technology and the routine offer of HIV testing using standardized patient registers, data cards and minimum data sets; improved integration of prevention and treatment interventions; population-based surveillance of drug resistance to inform drug selection and programming. In this regard, what follows is a discussion on what could be the possible benefits of integrating HIV and AIDS into the PHC in Zimbabwe.

2.9.3.1 The benefits of the integration of HIV and AIDS into the PHC

Moyo et al (2008:43) point out that consistent focus on HIV and AIDS treatment and care programs by government and donors has had some benefits for the health delivery system at large, albeit on a minimal scale. Dambisya (2009:4) is of the opinion that to some extent, the integration of HIV and AIDS into the PHC system has benefitted the whole system. In agreement, Moyo et al (2008:43) states that the provision of ART has become a lifeline for the virtually collapsed health system in Zimbabwe. Moyo et al add that logistics and infrastructure developed for HIV and AIDS services for HIV patients, including provision of ART counseling and (in some cases) provision of food, are now available in specialized clinics and this has reduced the workload in various departments and allowed health workers to pass on patients with other ailments. The opportunistic infections (OI) clinics located at central hospitals attend to all HIV related treatment, including provision of treatment for opportunistic infections, ARVs, counseling and in some cases food.

Accordingly, Moyo et al (2008:45) articulate that the situation in regards to ART has improved somewhat since the Zimbabwe National AIDS Strategic Plan (ZNASP) for 2006 to 2010 was initiated. There has been some normal benefit to the health system in that materials such as vans and cars for transport, that were provided (often donated specifically for HIV and AIDS) have also been used to increase health center's supplies of a far under range of medical equipment and drugs. The private sector and faith based mission hospitals have experienced enormous scaling up of services and programs. Although not yet ideal, there has been improved integration in the

overall system with VCT, OI, TB and STI clinics being used as entry points for ART and expanded care, a direct benefit of partner-initiated counseling and testing¹³⁶.

On the other hand, Dambisya (2009:4) is of the opinion that HIV and AIDS services have had both negative and positive effects on the retention of health care workers in Zimbabwe. Dambisya states that earlier studies reported negative effects of HIV and AIDS and the delivery of HIV and AIDS services on HCWs' morale, stigma, burn-out, resignation and death due to HIV and AIDS. However, more recent studies speak of hope, high prestige, high motivation and retention of HCWs in HIV and AIDS programmes largely due to effective ART which has improved the prognosis of AIDS.

2.9.3.2 The limitations of the integration

The integration of HIV and AIDS into the PHC has placed additional strain on the health care system thereby compromising its capacity to deal with other chronic diseases. In addition, Moyo et al (2008:45) assert that the health system was under attack but “the advent of HIV dealt it a death knell because HIV has potentially increased the number of people seeking health services that they are unable to access.” On the other hand, it can be argued that the training received by health personal has been inadequate to cope with HIV which impeded delivery of the other services. In addition, Dambisya (2007:9) is of the opinion that expanded HIV and AIDS services have revealed glaring shortcomings in the Zimbabwe PHC delivery system because the disease itself has had an overwhelmingly negative impact on the country's entire health system. Furthermore, Dambisya (2007:9) affirms that the Zimbabwean health status has deteriorated since 1995 due to a number of factors including HIV and AIDS pandemic, non availability of drugs caused by the deterioration of the economic situation and reduced quality of care and health facilities.

HIV and AIDS has further strained the PHC human resource base as one doctor is serving 8 000 people compared with the world standard of one doctor to 520 patients. Many health centres have no doctors and some clinics are being run by overworked nurses. Some communities especially those in rural areas are considered lucky if a doctor visits once a week. Dambisya

¹³⁶Moyo et al (2008:45)

(2009:4) adds that HIV poses a triple threat to HCWs by, increasing the burden of disease, imposing heavier workloads and increasing complexity of care with new demands such as ART. In this regard, Johnston (1998:39) states that rudeness and insensitivity of the HCWs is a significant factor cited by clients in the declining quality of care.

Moyo et al (2008:46) further argue that, although the number of people seeking health care services has increased with greater awareness of the potential benefits of HIV treatment, their ability to actually obtain access to crucial services has been hampered by the economic crises. Most Zimbabweans lack the financial capacity to pay for services, in an environment where both the government and medical insurance companies are scaling back their services and health care providers are demanding cash upfront for all services. Increasing and sustaining ART access thus renew major challenges while basic health care has become a luxury, few can afford.

2.10 Voluntary Counselling and Testing (VCT) within the PHC

VCT is the process by which an individual undergoes counseling enabling him and her to make an informed choice about being tested for HIV. This decision must be entirely the choice of the individual he or she must be assured that the process will be confidential¹³⁷.

2.10.1 HIV Testing

The diagnosis of HIV has traditionally been made by detecting antibodies against HIV and there has been a rapid evolution in diagnostic technology, since the first HIV antibody tests became commercially available in 1988¹³⁸. Within the PHC testing is conceptualized as the gateway to care and treatment. It is also the first point of access in attempting to address the epidemic. Hence, testing becomes the foremost priority in combating the HIV pandemic. Van Dyk (2008:252) points out that the HIV test is different from all other tests because it has emotional, psychological, practical and social implications for the client and should never be done without thorough pre-test and post-test counseling.

¹³⁷ Myaya (2004:2)

¹³⁸ Baggaley (1998:3)

2.10.2 Voluntary counseling and testing (VCT)

The primary role of VCT is indicated in The UNAIDS policy statement on VCT as quoted by Baggaley (1998:3) which states,

VCT has a vital role to play within a comprehensive range of measures for HIV and AIDS prevention and support and should be encouraged. The potential benefits of testing and counseling for the individual include, improved health status through good nutrition advice and earlier access to care and treatment/prevention for HIV related illness, emotional support, better ability to cope with HIV-related anxiety, awareness of safer options for reproduction and infant feeding and motivation to initiate or maintain safer sexual and drug-related behaviours. Other benefits include safer blood donations.

Figure 4: Voluntary Counselling and Testing as an entry point for HIV prevention and care



[Source: van Dyk 2005:104]

MOHCW (2004:6) states that VCT was formulated as an entry for HIV prevention, care and treatment. A national network of high quality VCT “New Start” Centres was established by Population Service International (PSI) in association with the Zimbabwe MOHCW. In addition, MOHCW asserts that most hospitals in Zimbabwe can carry out rapid HIV testing as well as full blood counts. Zimbabwe follows WHO recommended treatment to make guidelines for anti-retroviral therapy.

2.11 Elements of VCT

The elements of VCT are discussed below to highlight the services available to people who are infected with HIV.

2.11.1 HIV Counselling

Baggaley (1998:3) defines HIV counselling as, ‘a confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV and AIDS.’ The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventative behaviour. Van Dyke (2008:252) adds that the objectives of HIV counseling are, the prevention of HIV transmission and the emotional support of those who wish to consider HIV testing, both to help them make a decision about whether or not to be tested and to provide support as well as facilitate decision making following testing. Counsellors may come from a variety of backgrounds including health care workers, social workers, lay volunteers, people living with HIV and AIDS, members of the community such as teachers, village elders or religious workers/leaders. The counseling process consists of pre-test counselling, post-test counseling, care and support after VCT.

2.11.2 Pre-test counselling

The main purpose of pre-test counseling is to provide the client with the necessary information and support he/she needs to make an informed decision¹³⁹. van Dyk (2008:252) adds that the reasons why the client wants to take an HIV test needs to be explored. The client is informed of the implications of testing. Confidentiality is also discussed. van Dyke (2008:252) further explains that the client is prepared for the implications of both a positive and a negative result

2.11.3 Post-test counselling

Van Dyk (2008:258) asserts that although the post-test counseling interview is separate from the pre-test counseling interview, it is inextricably linked as both the pre-test and the post-test counseling interviews should preferably be done by one person. This is because the established

¹³⁹Etang (2009:23)

relationship between the client and the counselor provides a sense of continuity for the client. In addition, counseling after testing depends on the outcome of the test, which may be a positive, negative, indeterminate or inconclusive test result¹⁴⁰.

2.11.4 Counselling, care and supportive after VCT

L'Etang (2009:25) affirms that although the importance of intensive short-term counseling has been indicated, psychological support and intervention should continue until the death of the infected individual. van Dyke (2008:292) is of the opinion that, at present there seems to be a focus on pre-test and post-test counseling with inadequate attention given to the provision of psychological intervention and psychological support to those infected and affected by HIV and AIDS.¹⁴¹ Hence HIV and AIDS counseling should not be limited to pre and post test counseling.

2.11.5 Reflection on HIV counseling within the PHC in Zimbabwe

Although VCT in Zimbabwe is becoming increasingly available and considered important, its widespread implementation is often limited by lack of funding, infrastructure trained and designated staff, clear policies, staffing and service sustainability¹⁴². Counsellors often have other roles within the PHC which reduces the time available for counseling as a part of HIV testing. Myaya (2004:3) further asserts that in some instances, without adequate staffing and policies guaranteeing counseling as a priority, pre-test and post-test counseling are often not delivered at all or are done so hurriedly that clients are not given the time and attention they need.¹⁴³

¹⁴⁰L' Etang (2009:24)

¹⁴¹ This was confirmed in a study conducted by Coetzee and Spangenberg (2003) quoted by Etang (2008:25) on coping and the quality of life for people living with HIV and AIDS. The participants in this study felt that living with the knowledge of one's positive HIV status without follow-up care and support could lead to depression, despair and death

¹⁴² Myaya (2004:3)

¹⁴³ Baggaley (1990:7) discusses the issue of burnout-emotional exhaustion that results when a counselor has reached his/her limit to deal with HIV and its related emotional stress may result in rapid turnover of counselors. This is greatly true in high prevalence areas where the breaking of bad news may occur several times a day

On the other hand, Sibindi and Meursing (2000:17) concur that WHO and UNAIDS have consistently promoted HIV counseling as a routine part of HIV testing in developing countries. The same authors point out that in many countries counseling is not considered a crucial accompaniment of testing services and patients are tested without access to counseling during and after testing. Sibindi and Meursing add that in light of the developing countries, there is need for information on the need for and the results of counseling to convince policy makers and service managers to give greater priority to the development of counseling services. Hence this research endeavors to shade light in this regard.

In addition, Sibindi and Meursing (2000) in their paper entitled “HIV counseling- a luxury or necessity?” discuss a qualitative study describing informational, social and emotional needs and problems of newly diagnosed seropositive patients within the PHC in Zimbabwe. In this study they observed that the complex and changing nature of clients’ needs indicates that common short cuts in counseling are seriously flawed as a strategy to prepare for effective coping. Comprehensive pre and post test counseling are an essential preparation for coping effectively during and immediately after testing. Availability of supportive counseling beyond this first phase is essential to assist clients with needs and problems which will appear over time. Sibindi and Meursing (2000:17) recommend that, development of counseling interventions should be guided by research into their effectiveness in addressing the needs of the people living with HIV and AIDS.

As noted earlier in this chapter, the PHC in Zimbabwe has a colonial foundation that continues to plague it and its users. In line with this thought, Mkhize (1995:9) argues that the Western biomedical model of health care, treatment and counselling is unequivocally the only valid paradigm for official health care. Hence, traditional and alternative views of healthcare and counseling take a subordinate position, which can be detrimental, both to the quality of democracy in a country and the good mental health of the individual. For example, concerning psychological counseling Mkhize (1995:9) states,

Assumptions underlying counseling ought to be revisited and formulated within the client’s value system. Counselling is informed by appropriate client needs and values and explains strengths that are already in place in the client’s system. For example, we need

to learn more about respect and affirm the manner in which traditional communities deal with issues such as bereavement, recognizing the psychological and therapeutic values of such practices.

Accordingly, Mkhize (1995:10) is of the opinion that the typical Western psychology and philosophy view used in the PHC is that the individual acts independently and rationally in his/her sexual choices. Not all cultures share this view of individual autonomy as already indicated in this chapter. Mkhize further asserts that healthcare workers work with a cultural paradigm that says AIDS is caused by HIV, a virus without intent or morals. While the African client is of the view that one only gets sick, in such a manner if one is the victim of witchcraft. The burning question would be, is one true and the other one false? I find Mkhize's critic about the relevance and effectiveness of psychological counseling used in HIV counselling, important especially if one is working with populations that have been adversely affected by outside forces like in Zimbabwe.¹⁴⁴ For example, an external locus of control is an appropriate and realistic response for a client whose well being is affected largely by external factors. As Mkhize (1995) has asked, "Is the Western model of counselling appropriate to the South African context?" The same could be asked of Zimbabwe. Hence the aim of the study was to explore, with the people living with HIV and AIDS, whether spiritual care could be an alternative model of caring for people living with HIV and AIDS in Zimbabwe. I wanted to co-create with the participants a spiritual and pastoral care approach which is contextual and relevant to the Zimbabwean context in terms of addressing their spiritual needs. It is against this backdrop that in the next session, I further examine what I considered to be the missing gap in the implementation of HIV counseling within the PHC in Zimbabwe as part of a holistic approach to the care of people living with HIV and AIDS.

¹⁴⁴UNAIDS (2001:15) establishes that in Sub-Saharan Africa to include Zimbabwe, counseling services prior to HIV were rare and the concept of 'formal' counseling was unfamiliar to most people. In the African societies there were well established systems for community and discussing health problems and issues concerning adolescent sexuality, commonly involving community elders or trusted family members as the educators. However HIV has not often been adequately incorporated into these structures. Subsequently, HIV counseling services have been developed through often in a piecemeal fashion or associated with research projects.

2.12 The Missing gap within the holistic approach to the care of people living with HIV and AIDS.

In light of the above discussion, acknowledgement is made of the different types of psychological counseling being offered to people living with HIV and AIDS within the PHC. There is evidence that their emotional, social and psychological needs are addressed to some extent. However, my argument for conducting the research was that, HIV and AIDS affects the totality of what it means to be human. The recognition by the policy makers that healthcare needs of patients, has to be holistic and that it is the whole person to be cared for, for the best outcome for people living with HIV and AIDS, exerts an expectation that spiritual care should also be incorporated into clinical practice in order to address the spiritual needs of patients. If this be the case, then surely it is the clinical staff that should be responsible for the patient's mind, body and spirit. My argument was that, offering psychological HIV counseling within the PHC in isolation from spiritual care would appear to defeat the objective of a holistic approach to care and counseling of people living with HIV and AIDS as stipulated in the ZNAP. My assumption was that given that eighty percent of Zimbabwean people believe in God or higher power, ignoring matters of spirituality is disastrous to a holistic approach to care of people living with HIV and AIDS. On the same note, Van Dyk (2005:244) admits that, researchers often refer to the importance of dealing with the spiritual needs of HIV positive clients and their loved ones, but this process remains one of the most neglected aspects of counseling especially within the HIV and AIDS context. In an attempt to fill this lacuna, the present study quested for a spiritual and pastoral approach to healing in addressing the spiritual needs and spiritual problems of people living with HIV and AIDS within the PHC system of Zimbabwe, which is an under researched area.

Furthermore, Florell (1990:1320) defines holistic health care as 'an interdisciplinary approach in which patients play an active part in their own health planning. The emphasis is as much on health as on treating illness and involves treating the whole person physically, emotionally, psychologically and spiritually'. In this regard, I wanted to study and understand the spiritual needs and problems of people living with HIV and AIDS from their perspective. The people living with HIV and AIDS were positioned as the 'knower' or experts of their own lives.

Furthermore, I wanted to explore ways of making spiritual care of people living with HIV and AIDS relevant and contextual. And to achieve this, I worked with the people living with HIV and AIDS as co-researchers, co-authors co-creators and as participants throughout the research. Together we co-created spiritual care with the participants, which was relevant and contextual. The possibility of integrating and addressing the spiritual problems and needs of people living with HIV and AIDS receiving care within the PHC has not been explored by past research in Zimbabwe.

The present research attempted to fill that gap, as people living with HIV and AIDS became co-researchers and collaboratively, explored the possibility of integrating the spiritual care of people living with HIV and AIDS into the PHC as part of the holistic approach to their care. Hence, I am convinced that, a strong functioning public health care delivery system is critical to addressing a generated epidemic such as that found in Zimbabwe. I acknowledge that Non Governmental Organizations (NGO), Faith Based Organizations (FBO) and private sector-operated programs are effectively leading in certain target populations in the care and counselling of people living with HIV and AIDS. However, they do not have national coverage. My assumption therefore is that supporting the PHC delivery system, with its widespread infrastructure, is the most effective means of reacting to the care and counselling needs of people living with HIV and AIDS rather than creating a parallel system. The research intended therefore to demonstrate the advantages to the health profession itself, to the policy makers, as well as to the public, of an integrated approach to care and counselling of people living with HIV and AIDS where there is an inclusion of spiritual care of people living with HIV and AIDS within the PHC delivery system as part of a holistic approach to their care.

2.13 Conclusion

This chapter proceeded on the understanding that HIV and AIDS is a global threat with very locally down to earth consequences. The assumption was that HIV and AIDS is a disease of society and not only a medical issue. Therefore, the context in which the pandemic is embedded becomes important in understanding the etiology of the HIV epidemic and the widely diverging HIV and AIDS pandemics in Africa or anywhere else. In this regard, the chapter discussed the social, economic and political determinants of HIV and AIDS in Zimbabwe indicating how these

have fuelled and sustained the evolution of HIV and AIDS in Zimbabwe. The chapter revealed that the Zimbabwean society is multi-faceted, having innumerable features that might be measured and tested for their potential contributions towards the evolution of HIV and AIDS. However, despite its ongoing political, social and economic crises the decline in HIV prevalence in Zimbabwe is one of the most significant and rapid declines of any country in the world. Responses about the decline in HIV prevalence in Zimbabwe were varied and relatively low despite the potential importance of the statistics. It was noted that, while numbers matter for funders, they do dehumanize the people they claim to serve.

The chapter acknowledges that, despite the promising news of the decline in HIV prevalence, new HIV infection rates in Zimbabwe remain unacceptably high and women and girls continue to be particularly vulnerable. Although the international response to the HIV and AIDS pandemic in Zimbabwe is noted, much emphasis is placed on how GOZ has responded to the pandemic. Hence the establishment of NAAC as the country's coordinating body is discussed with specific reference to the Zimbabwe National HIV and AIDS Policy for Zimbabwe (ZNHAP) as an important policy document to guide the national response to the pandemic. In the National Policy on HIV and AIDS for Zimbabwe the rights of people living with HIV and AIDS are acknowledged as needing special consideration. Hence, providing care and counselling is noted as essential in order to minimize the personal and social impact of HIV and AIDS. The chapter further indentified what I consider to be a puzzling blind spot, within the ZNHAP in terms of the HIV care and counselling offered to people living with HIV and AIDS within the PHC delivery system. However, the policy document is silent about the spiritual problems and needs of people living with HIV and AIDS and my argument through this research is that people living with HIV and AIDS have spiritual problems and needs which need to be addressed within the primary health care delivery system, as part of the holistic approach to their care. I further argue that, offering HIV care and counseling within the PHC in isolation from spiritual care, would appear to defeat the objective of a holistic approach to care and counseling of people living with HIV and AIDS. Although a lot has been written about the needs of people living with HIV and AIDS, I wanted to hear from people living with HIV and AIDS themselves what their spiritual problems and needs were and together explore how they could be addressed within the Primary health care delivery system as part of a holistic approach to care. Hence chapter three

focuses on the participants 'stories which they shared during the research journey as backdrop to understanding their spiritual problems and needs.

CHAPTER THREE

STORYING THE UNSTORIED: PROBLEM SATURATED STORIES

3.0 Introduction

This chapter gives the backdrop to the research question, by narrating the stories of the seven participants as people living with HIV and AIDS who are receiving care at Gweru Provincial Hospital in Zimbabwe. The aim of giving “voices to the voiceless” by “storying their unstoried” experiences¹⁴⁵ of being HIV positive was, to assist me as the researcher and the participants to understand the context in which the spiritual problems and needs of the participants are embedded. Part of the purpose of storying the participants’ experiences was to, deepen the co-researchers’ own understanding of their HIV and AIDS experiences, spiritual issues and concerns under consideration. Therefore, I gave the participants a voice, which could be heard among the many other voices, which speak of the experiences of living with HIV and AIDS. All the seven stories recorded in this chapter are problem saturated stories (1.12.1.3.10.1) according to narrative therapy. The stories in this dissertation are true although names and minor details have been changed to obscure identities. I endeavored to tell each participant’s story faithfully and each story is treated with dignity and as unique and important as supported by Eberhardt (1996:24),

Stories can exude both pleasure and pain. Our interests in the stories of others tell about themselves and their activities are indicating of how their pleasure or pain touches our own pleasure and pain.

For the voices of the participants to be seen in the text, they are typed in a different font. The different spiritual themes that emerged as the stories unfolded are presented in Chapter Four. I intentionally refrained from interpreting or commenting about each story. However, I deeply engaged in the questions and issues which I asked myself as the stories were told. I present these as reflections at the end of the chapter. The participants’ stories represent their own experiences and are not necessarily representative of the lives and experiences of other people living with

¹⁴⁵Isherwood and McEwan (1998:87)

HIV and AIDS in Zimbabwe or anywhere else on the globe. This is in line with the postmodern epistemological perspective, where reality is not perceived as an objective given but instead knowing is seen as inherently contextual “because within this approach the knower helps constitute what is known”¹⁴⁶. I make no claims to the discovery of ultimate truths in terms of identifying and understanding the spiritual problems and needs of people living with HIV and AIDS. The contextual nature of the participant’s knowledges makes it ‘impossible to voice large truths. All one can do is to voice local truth and propose that it pertains elsewhere.’¹⁴⁷

The locally claimed realities of people living with HIV and AIDS who shared the act of documenting the research journey in various capacities was therefore honored by giving them a chance to speak as theologians in the academic discourse. The purpose was not so much to search for truth, but to begin a journey in the process of spiritual healing from the spiritual pain experienced by people living with HIV and AIDS. I sought to make the assumptions and mental models of the experiences of these seven people living with HIV and AIDS, more explicit, so we can collectively continue to learn with each other, about alternative ways of caring for people living with HIV and AIDS. Finally, what is written here comes through my own voice, deeply influenced by my co-researchers and others with whom I have conversed, by books I have read and by my own ongoing internal processes of reflecting, observing, assessing, intuition and analyzing. I am limited and this study will both benefit from and be restricted by these limitations. I became interested in exploring what could be the link between the co-researchers’ experiences of living with HIV and AIDS, the meaning they attached to that experience and how the social structures, culture, and their spirituality are interlinked to that experience.

3.1 Storying the unstoried

This section is the core of my dissertation where I share the stories of the seven people living with HIV and AIDS I journeyed with in this research journey. There are differences in their stories and there are common themes as well. The differences mean, there is no single set of right conditions. One of the aims of narrative inquiry involves a focus on “story” and the effects of

¹⁴⁶ . Brueggermann (1993:8) and Astley (2002:59)

¹⁴⁷ Bruggermann (1993:9).

telling particular stories and the effects of telling particular contexts. The story that is not there is the “unstory”¹⁴⁸ which is explained by Bons-Storm (1996: 57-58)

Some experiences stay “unstoried. They cannot be given meaning that somehow fits in the fabric of a developing self-narrative. This happens to experiences that are painful and shameful. They are put in a closet, the doors shut. To put those experienced events into words and to tell another person the story would mean not only letting the experiences, but also the pain and the shame attached to them out of the closet. One can only do this if one is absolutely certain that the listener will understand and acknowledge the pain and the shame and nether less accept the person who tells the story. If the pain and shame are very deep and confuse the self narrative too much and thus the search for an authentic identity the experienced event drops more or else out of consciousness and be core or less forgotten.

Before this research, the participants could not communicate their experiences of living with HIV and AIDS so these experiences stayed ‘unstoried’ till they found somebody (in this case myself and the rest of the group) to share with some of their “unwordable experiences”¹⁴⁹. By creating space for them to tell their stories, the people living with HIV and AIDS were able to make choices about their preferred ethical ways of living. As we listened to each other’s story, we looked at each participant as valuable persons in their own right. In the research, I was interested in introducing the participants to the reader in a way that was power sharing and in keeping with the participating spirit of the study. I asked the participants to say, how they would want to introduce themselves and in this way they introduced themselves using their pseudonyms rather than being introduced by a third voice. Hence their voices became heard from the beginning. It is noteworthy that due to the limited space, the stories provided are not the full stories of the participants. I admit a bias in the selection of the ‘story parts’ as only the summaries of the stories are reported in this chapter. However, after the summaries were made I gave them to the participants for them to make corrections, comments or additions. The input of the research participants was honoured. After each story there would be some reflections from

¹⁴⁸ Laird (1991:437)

¹⁴⁹ Bons-Storm (1996:59)

the other participants. In this regard, they became the reflecting team (1.12.1.3.11.9.1). These reflections only represent part of the conversations which I had with the participants.

3.2.1 Mai Chipo tells her story

I tested positive in 2006 after I had been sick for a very long time. I had tried everything the prophets and our traditional ways but nothing worked until I went to the hospital to be tested for HIV. I tested positive and I started on ART. I am married but we fight a lot with my husband. I have lots of scars on my body because of these fights. He drinks a lot. I got the disease from him. I have never known any other man in my life. Although we married each other as a boy and girl, now we fight a lot. He is not very sick but his problem is drinking. And yet he never paid lobola for me. We had one child who died and we left it like that. Last time when we had a fight I almost killed him. By now I could be in jail. I beat him up because I was stronger than him since he was drunk. He left me and went to stay with his girlfriend but he came back after a week.

Now I want to go to South Africa to work. I don't have much money. My relatives said I should get a passport and go to South Africa to work. My mother is a widow and she is taking care of many orphans and I am the only one who is helping her. On my husband's side, there is nothing to help me. Here if I get a job it does not pay. I am the bread winner. My husband doesn't work and when he gets part time jobs he spends it on beer and girlfriends. If I am paid fifty dollars I need to pay rent and buy food. The money is not enough

My passport is already out. If I go and work in South Africa I will send my mother some money and build her a better house. At least when I die she may say my sick daughter did something for me. Now I do part time work as a maid. What can I do? I can't leave this job now because there is no one to take care of me since I am already an orphan. With my husband we have been married since 1983. We once separated for a year. I remained and my mother in law got me a job. She used to encourage me to stay saying my husband will come back to me. He married another wife and came back. I am sure this is when he got the disease. By then he was suffering from TB. At that time we didn't know that TB could be related to HIV and AIDS. He was on treatment but it took time for him to be better. When I saw the woman he had married I was scared because she looked sick. After a while she just left. Then my husband went and took a

policeman's wife. By then I was also sick. I had herpes for three months and my mother came and took me. He remained with the policeman's wife. But the policeman's wife left him for these gold miners because my husband had no money. He was a builder but now his legs give him problems and he can't work. He is also on medication. I sometimes bring his card here with me because he can't walk to collect his medication. But the moment he feels better he goes to drink. He doesn't do anything at home to help me. Sometimes when he gets money, that's when he buys chicken pieces for a dollar. I am realizing that he is wasting my time.

At least I am working. The money I get, I sent some to my mother and I take care of myself. That's why I am presentable like this. The lady I am working for is also sick. She had a problem of not taking her tablets. But for her, she goes to a private doctor. She doesn't come here because they have money. I am the one who encouraged her to go for TB and HIV and AIDS tests. She went and she tested positive. I shared with her that I was also HIV positive and I have been on ART since 2007. She was surprised because I look fit. She has now accepted it but she was scared to tell her husband. I told her my own experience of how I told my husband since I tested first. At first my husband was afraid thinking that we had AIDS. But I explained the difference between HIV and AIDS to him. We came here at the hospital and we were taught. I also told my boss how I explained to my husband that we needed to take care of ourselves especially when we meet on the mat¹⁵⁰. But it's difficult when you are used to a wet¹⁵¹ one and then you use the plastic.¹⁵² It's difficult. So from then on she went to tell her husband. The husband, wife and child went to be tested but the husband wants to use herbs. The herbs do not agree with what we are suffering from. They eat well but the problem is in the blood. His problems are many because he is also diabetic. Now he has diarrhea and I am sure with time he will take the ARVs.

We fight a lot with my husband mainly because of his drinking problem. A drunkard and one, who does not drink, do not agree. He spends the whole day sleeping until in the afternoon, then he goes to drink. He comes home late and he opens the radio full blast. I used to ignore but it became a problem to me since when I got to work I would want to sleep. One day he came home

¹⁵⁰ Meeting on the mat is a metaphor for sexual intercourse

¹⁵¹ A wet one is a metaphor for having sex without a condom.

¹⁵² Plastic is a metaphor for a condom.

late and drunk and put the radio on full volume. When I complained, he told me to get out. I got out. It was around one in the morning. I met up with the patrol police and they asked me where I was going. They took us both to the police station. The police said he might be abusing me. They warned him and it only worked for a month, then that weekend, when I nearly killed him he had done it again. I got out of the house and I wanted to go to my mother. Before then he had bought me three pants. He said if I was going to my mother I must leave the pants. I gave him the pants and then he threw them into my face. I got very angry and I beat him. I lost my mind. That day I beat him a lot. I almost broke one of his ribs. He fell down and I sat on him with all my strength. He cried and mourned. People came and were laughing at him, saying he was beaten by a woman. This was the second time. The first time I also left him half dead. I realized that this was a demon possessed man. That's why I want to leave him and go to work. He doesn't do anything for me. I don't really want to go to South Africa. It's desperation. He never paid lobola¹⁵³ and now I am old and HIV positive which he gave me. Every time my mother asks for the lobola, he just says he will look for the money but he never does. My life is very painful. But I keep time for my medication and I take care of myself. I always wonder why God allowed this to happen to me.

3.2.1.1 The participating team's reflections on Mai Chipo's story

I asked other participants what moved them in Mai Chipo's story that they might wish to discuss.

Mukoma K.K

The whole story touched me. What really stood out for me is the repressed anger towards your husband. You sound very angry with him as you said because he gave you the disease and he drinks a lot. You don't seem to be happy with your husband. You want to go away to South Africa because he is not helping you and supporting you in anyway. That lack of support from your husband must be very hard for you. What came through for me also in your story is the way you try and help yourself. It shows a lot of inner strength despite all the problems you are having with your husband.

¹⁵³Lobola is the bride prize.

Amai Paida

I am deeply touched by the whole story and I can relate to some parts of her story. What came through for me is that, the life of a Black woman is not easy and now it's worse because you are HIV positive. You related incidences when your husband married other women and when you also knew he had girlfriends even the one whom you suspect to have given your husband the disease but you remained married to him. He beats you up, he doesn't support you he didn't pay lobola for you and he gave you HIV. Even now you are talking of going to South Africa to work and help your mother but you are not talking of leaving him. To me, this shows a great commitment to your marriage which I think is in most black women. And I wonder why?

Mother

The whole story is so moving. I really want to cry. What I relate to in this story is the self pity which I heard. When you spoke of not having enough money, and there being no one to help you and that you are an orphan it touched me a lot because sometimes I feel the same. I feel like there is no love in this world. I feel sorry for myself for being infected with HIV in the first place. I sometimes ask myself why I was so stupid. Why did I do it? But it's already done and here we are. However what I liked about you is the way you are taking care of yourself and of your mother. To me I see someone who is very caring. Maybe that has contributed to you having to stay with your husband all these years. You are a strong woman.

Mainini Shupi

Your story is also almost like mine. When you said I got the disease from him I felt like I was the one talking and I realized that, when you are HIV positive and being a wife life is very tough. What I related mostly to is the bitterness you have towards the husband. It's very difficult. How can you forgive someone who has taken your life away by giving you HIV? On top of that the husband abuses you emotionally and physically. You said you have scars from the beatings you got from him. But you stayed with him. You are the one supporting him and coming here to take his tablets. You work to pay for rent and buy food. He didn't pay lobola for you. That's what we do as married women. Is that love?

Mukoma T.J

When you spoke about your husband's unfaithfulness, it touched me a lot because I can relate to that as a man. I was wondering whether that is what my wife feels about this whole thing. From the whole story, what came through for me is that, the marriage relationship is in trouble because you said you have realized that he is wasting your time. I can also relate to the involvement of the relatives in your marriage. The suggestion they gave you to go to South Africa maybe that's the best they could come up with and you may want to take it up since you already said your passport is out. On the other hand, I hear you saying that if you would get a job here, you would want to stay. To me it sounds like desperation. You are in a desperate position. Life is very difficult and you have nowhere to turn to. But I saw you smiling when you spoke of building a house for your mother and the way you would want to be sending her money. To me it shows that you are a responsible person who is caring too.

Mukoma Tippy

What came through for me in this story apart from all the pain and suffering involved is the inner strength to move on with life. I see a very strong and courageous woman who wants to work for herself. Right now despite the difficult life you are working as a maid. And where you are working you were able to help your boss and the husband and child to go and get tested. You educated them on HIV and AIDS and you even shared with the wife your personal testimony of how you are living with HIV. And looking at and listening to you gave her courage to go and get tested. You saved their lives my sister. You remind me of the Bible story of the maid in Naaman's house who told Naaman's wife about the prophet in Israel who could heal him. He listened and he went to Israel to see the prophet and he was healed. I am sure as you continue talking to your boss about the success story of ART, her husband one day will start taking the ARVs.

3.2.2 Amai Paida tells her story

I tested HIV positive in 2007 and started on ART in 2008. I became sick in 2008. I have a child of 2007. After giving birth that's when I became very sick. I tried everything. I went to the faith healers as a born again Christian. It didn't work. I went to the traditional healers and it didn't work either. Nothing could help me. My husband refused to be tested. He is now a health worker

but after being educated he still refuses to be tested. He doesn't believe the HIV story. My worry is what will happen when we want to have another baby? Already we have four children, one girl and three boys. Suppose we want to have another girl what will happen?

At first when I got tested I was not sick. I got tested because I was pregnant. I couldn't believe it. I kept telling myself that it was not true. Then when I told my husband he also said it was not true. When I was delivering my baby I didn't even use that tablet they gave me because I told myself it was not true. After breast feeding for six months that's when I became very sick. I haven't had the child tested. I never asked my husband where the disease came from. My husband had another wife before we got married. I was a girl when we got married and I have known my husband alone. But I am the one who went to be tested and I tested HIV positive. I just thought maybe I am the one with the problem. It's like if you go to the traditional healer and he says you are the witch, whom do you say has the problem? Maybe he will change his mind and get tested before it's too late. But what if he wants another child? I am just thinking in the flesh.

The problem is that people in the village look down upon me. I never told anyone about my HIV status but the villagers got to know about my status because of these projects which are being done by some people who come to the village. They say when we are at a meeting, those who are taking tablets stand on your own so that we can give you less work. And when you stand up, everyone knows you are on tablets and they look down upon you. They think if you are taking tablets you are not strong and you are not normal. And sometimes they may think you are mad because you are on these tablets. Most people think that those who take tablets everyday are mad. Even if you say a point at the meeting, they don't take it seriously. They may be thinking she is mad. Or they say maybe she forgot to take the tablets today now she has lost her mind. It's very hard and when I move around the village sometimes I feel like I am mad.

I have never told anyone at church about my status. The pastor does not know. I pray to God about my situation and I see God helping me. Sometimes my life is very difficult and I ask God why all these bad things are happening to me. My family doesn't know about my HIV status. My neighbor in the village is my own brother but he failed to help me when I needed help most. When I was sick my own brother could not do anything to help me get help. He never came to visit. I took days praying to God to give me strength to walk to the clinic. One day I woke up with

all my strength and I walked seventeen kilometers to the clinic to get help. When I came back, my brother came to ask me how I had managed to walk to the clinic. He had a scotch cart and donkeys to help me with but he refused. Now he was surprised how I had walked to the clinic and back. My own brother could not help me but my God gave me strength. But I never stop asking why I am sick from such a dreadful disease? Why me?

3.2.2.1 The participating team's reflections on Mai Paida's story

Mother

I am really touched by your story Mai Paida and I can relate to it very well. What came through for me is that your husband, since 2007 up to now he is still refusing to get tested. Life for a married woman in Zimbabwe is hard. You blame yourself for being positive because you are the one who went and got tested because you were pregnant. Something must be done about these men who refuse to be tested. Now it's you who has to carry the burden by yourself. And when he becomes sick, that's when he will decide to be tested and sometimes it will be too late. What I like about your story is that despite your husband's denial of the situation, you seem to be living positively. You are even thinking of having another child. To me this shows that you love life no matter what it has brought on your life.

Mukoma T.J

What you said about the people in the village looking down upon you, to the extent of them thinking that you are mad is very sad. Sometimes people can be very cruel. Now you said it's affecting you because sometimes when you are moving in the village, you also feel like you are mad. I wonder whether people know that they will be stigmatizing you and labeling you. That is the reason why most of us do not disclose our HIV status. If you tell them they start calling you names like that. Life is difficult. I also noted that you did not disclose your status at church. That is a good thing because the people at church will even discriminate you more. They will judge you and call you sinner. You end up nowhere. You keep it to yourself.

Mukoma K.K

What touched me in your story is how your brother failed to help you when you were sick. I can relate to that myself. You find the closest people to you, who are supposed to help you when they just suspect that you are HIV positive or when they know that they don't want anything to do with you. It's very painful when your own flesh rejects you because you are HIV positive. But what I really admired in your story is the faith you have in God and how that faith in God helped you when no one else did. That I liked and I wish I could have that kind of faith in God. Your testimony is powerful. Maybe you can help some of us to develop that kind of faith in God. To have no doubt about God that He loves us no matter no one else cares, even our own brothers or sisters.

Mainini Shupi

Your story is almost like mine and I can relate to it so much. The fact that your husband refuses to be tested after all these years is not so surprising. It's like most of our Black men. They can only take an HIV test when they are sick after they have tried everything else and it has failed. Then when they are on their sick bed then they have no other choice but to test and most of the time it will be too late. They will die still denying that they are HIV positive. And yet if people can be tested earlier it can help them to be on ART earlier and live healthier lives. I do agree that the government must do something about men who refuse to be tested, when the wife is positive. The other thing which really touched me is the strength you had when you were sick and you said God gave you power and strength to walk seventeen kilometers to the clinic. To me, I see a very strong woman who has a wonderful relationship with God and nothing will stop you from getting what you want. It reminds me of that woman in the Bible, who had been sick for twelve years and she was determined to be healed. She purposed it in her heart to touch the hem of Jesus' garment and she was healed. She didn't care what people would say or think about her. Whether people thought she was mad, she was determined to get healing by herself and that faith helped her and I see that in you.

Mai Chipo

Your whole story is a story told by many women in Zimbabwe who are HIV positive. What really touched me most is that you married your husband when you were a girl and he is the only man whom you have known. He was married before and now you seem to blame yourself, to say since you are the one who was tested then it's you who has the disease. This is the fate of many women who are HIV positive. You have only known one sexual partner in your life who is your husband and you have never been unfaithful to him. But he brings you HIV and AIDS. You can't refuse to meet with him at the mat because he is your husband and he will tell you I paid lobola. Marriage has become very dangerous these days of AIDS. This is very painful. At least we know now it's not a death sentence because we take the ARVs but the challenge is what do you do when the husband wants a child? Living long with HIV has its many challenges and we need help.

Mukoma Tippy

I also find your whole story touching. I have never disclosed my HIV status to anyone at church and even the pastor does not know that I am HIV positive. It's very difficult to trust anyone at church with your secret. If you tell the pastor he will preach about it and everybody will know about it and they will discriminate you just like those people in the village. Yes, at church you have no problem because they don't know your status. The day you will tell them things will change. Both people in the village and at church are just the same. They stigmatize us and sometimes people at church are even worse. And yet they preach about love. But you have so much faith in God and I admire that. You look quite positive about life and you are even thinking of having another child. But I want to say to you, take your last child for testing. It is better to know early and get help if the child turns out to be HIV positive.

What I can relate to in your story is the fact that no matter whatever is going on in your life and marriage, you are still with your husband and children. And you are thinking about having another child with your husband. As a married woman you want to stay married and continue family life like any other normal family. To me, that shows a lot of courage and a strong will to live. And unlike some of us in the group you don't stay in town. You stay far away in the resettlement areas where there is no clinic. But because of your strong desire to live, you walked

seventeen kilometers alone to the clinic to get help and here you are today, looking well and full of life. I admire that inner strength in you.

3.2.3 Mukoma K.K tells his story

I was tested in 2010 but I am not yet on ART. And Today I came for my CD4 count results. I am concerned that the nurses did not explain anything to me. Usually I just come here and get my results but today they referred me to another office without any explanation and I am concerned. My past record here in my book shows that my CD4 count is going up. Maybe it is because of my lifestyle. I follow everything they have taught us here at the hospital. But my wife is already on AR T. In 2010 my wife became very sick. There is no medication I didn't buy. She got worse. We went to the traditional healers. It did not help. She went to the prophets. It got worse. She had TB and many other diseases. I suggested to her that we should both go to the hospital for an HIV and AIDS test. We went together and we both tested positive. She started on ART straight away. Now she is fit. We just do what the nurses teach us here. We make sure that when we meet on the mat we use condoms. But having sex is no longer enjoyable using condoms. It's not natural.

And our HIV status is our secret. We haven't told anyone about it. Our children don't even know about it. The secret is between the two of us. I was lucky in the sense that my wife was once married and her husband died. When she also tested positive we accepted just like that. No questions asked. If she wanted to blame me, how was she going to do that when her former husband used to have many girlfriends. I support her a lot when it comes to taking the medication. Every night before we go to bed, I ask her whether she has taken the medication. And this has helped to keep our secret safe. We have been married for eleven years and we have one child together.

I was once married too. My first wife was taken by another man. She used to stay home and people would tell me that my wife was sleeping around. So every time I would go home I pretended to be sick so that we would not meet at the mat. I totally refused to sleep with her until she was made pregnant by another man. The boyfriend was a policeman. We have five children together and they stay with her but others are already married. I tried to get my children but the police could not allow me. They are very rough people. Things have changed now. The police

support women in this country. Instead of getting your children, they give the children to the wife. But I see my children although their mother is no longer with me. The police favor women in Zimbabwe. You tell them my wife was given a baby by another policeman. They tell you that it is not important. And they clap you when you say that. Life is very difficult but you just leave everything in God's hands and let Him be the judge. Now I am HIV positive and I have all these problems. I always ask myself why life has been so unfair to me. Does it mean I don't deserve happiness? One wife was taken by another man when I was busy working for her here in town and the next woman I marry gives me HIV. What does that mean? I have no answers to all these questions but they keep me awake every night.

3.2.3.1 The participating team's reflections on Mukoma K.K's story

Mainini Shupi

I find your story very touching. What I relate to is the way the nurses did not explain about why you had to go to another room for your CD4 count results. Usually they just give you your results without any problem. Why today? And it's very difficult to ask them. You can't ask. You just worry and many things will be going on in your head. It's better for the nurses to tell you the reason why you must go here or there. But what I like is that, he supports his wife who is already on ART. And that he has already tested unlike most men who wait until it's too late. For him he went for the HIV test together with the wife although he was not sick himself. To me he stands out as a very supportive husband. Others if it is the wife who is sick they just let the wife go for the test alone and when the results are out it is the wife's story alone to worry about how to tell the husband the positive results.

Mukoma T.J

The story is very touching and I can relate to most of the issues you said in the story. Your first marriage did not end very well. There are issues of infidelity with the first wife and the problems attached to that are many. Even when you tried to get your children the police are not very helpful. But that did not keep you alone. You are now married and you have a child with your new wife. To me it demonstrates a lot of courage and a strong will and desire to leave a normal life because life without a wife is very difficult. You become lonely and you miss out on the

opportunity to love again. I find this very encouraging because some people after experiencing such hardships in a previous marriage they vow never to marry again or to love again. Although in the new marriage you now have the challenges of being HIV positive but you are there for each other. You support each other on your medication.

Mother

I am really touched by the way you want to keep your HIV status a secret and even call it a secret. I relate to that myself because it is very difficult to disclose your HIV status to people even to those who are very close to you. I did the same when I tested positive. I found it very difficult to even tell my own children that I was HIV positive. When I tested positive, my children were also big and my other daughter was already married but I didn't know how to tell her. I didn't know how to tell my husband. I didn't know how to tell my mother or any other relative. I didn't know how to tell the pastor or other church members. At the hospital after testing and they told me the results no one told me how to disclose my status. The counselor just said it was necessary to tell my husband so that we can start using the condom. Life became very difficult. It's very difficult to find someone you can trust but on the other hand you know that you need their support. The people at home and at church, they are all the same. So you become afraid of being discriminated and isolated. But if you can find someone who is also HIV positive then it's easy to open up and share otherwise this can be your secret till you die.

Mai Paida

I am really touched by the story and I can relate to the story very well. But I am mostly touched by the way you support your wife. When she was sick before she was tested you tried everything trying to get help for her. You even went to the traditional healers and even the prophets. But nothing helped. Most of us we have gone that route. The first thought when you become sick with this illness, is to go to the traditional healers but it seems the traditional healers are failing to help. They tell you about what the ancestors have said and the rituals you have to carry out. You do all those things but you find you will be getting worse and worse. Then you try the prophets. You say the prayers and use the holy water but still nothing helps. Until you come to your senses and go to the clinic or hospital to be tested. After that if you follow what they teach you here you

will be fine. But what I liked in your story is that you have been there with your wife through it all and up to now you are still together.

Mai Chipso

Your story is very touching. To have your first wife taken by another man is not easy. And the fact that she had a child with the other man is also very difficult to take in. How does someone make sense of their life when such thing comes your way? It's very difficult. And now you can't have your children with you. The police don't seem to want to help you. But life has to go on. You seem to be doing a very good job taking care of your health and since you tested up to now, you haven't started taking ART. To me I see a very strong and determined person who will not allow problems to stop him from living his life. Now that you have found new love it's so encouraging.

Disclosing HIV positive results is very difficult. We are all afraid of being isolated, called names and discriminated. Sometimes you can't visit people because you will have to take your tablets and then people will know. The people at church and at home are the same people, they will discriminate you if they get to know your status. It's very difficult to find someone you can trust to love you unconditional when they know you are HIV positive. There is no love anywhere and in some cases in the church it's even worse because they will judge you even if they don't know the truth. So sometimes it's best to keep it between the two of you. The good thing about you is that, there is an understanding between you and your wife. So that secret will be kept safe, without worrying about people and what they are thinking.

Mukoma Tippy

The way you accepted your HIV status is very touching to me. You don't seem to blame anyone to have brought the HIV although you pointed out that her former husband was promiscuous. The point is, you didn't play the blame game. Between the two of you, you just accepted and mapped your way forward. You have managed to stay off ART ever since you tested positive and you shared that your CD4 count seems to be going up. You said you follow what they teach you here at the hospital and this is helping you a lot. For some of us it's a big struggle especially when the two of you cannot support each other. Life becomes very hard when the two of you

cannot support each other. The blame game and the accusations will be many. What you can only do is to ask God for the reason for all the suffering.

3.2.4. Mainini Shupi tells her story

Today I came to take my tablets and will be back in June for another refill. I was tested last year in March. That was in 2011. I was very sick. I went to see traditional healers but it didn't help. For two years I had diarrhea. I also went to churches but it didn't help. But from the time I came here at the hospital the diarrhea stopped. But I have another problem of constipation. The whole week I can go to the toilet only twice. And I will be forcing myself. Now I have another problem although I am on ART. I urinate a lot as if I am pregnant. I shared this with the nurses here at the clinic and they changed my medication but it's not helping. I only take one tablet a day.

I am thirty eight years old. I am married. I have no child. I am staying with my husband but it's just by force. When I was sick I refused to be tested and he said it was my fault and I gave him the disease. I told him how that could be since he slept around a lot. When we got married, he was just like that. Up to now he hasn't changed and he hasn't taken an HIV test. I wanted children before I tested HIV positive. But now I can't be pregnant. My periods stopped in 2009. I don't know whether it's this disease. I went to a spirit church many times. Each time the prophet would help me, it will only work for three months and stop. They finally told me to go to the four corners of the earth. I came to the hospital and the nurses told me, it was possible with these tablets we are taking.

I have disclosed my HIV status to my mother. But my mother doesn't support me at all. It's like she thinks I deserve this disease because I married this man whom everyone knew that he was sleeping around. Even when I was sick my mother never came to visit me. She doesn't love me. My husband doesn't love me. He doesn't support me. He doesn't help me at all. Since he has not tested, he blames me for giving him the disease. But I ask him why, he says that since he hasn't tested. He just says he knows women like me cheat on their husbands. It's like there is no marriage there. I no longer want to be with my husband. He says very hurtful words. My life is very painful. I have never known happiness. It's that I don't have money to start a small business or to go back to school. I am working part-time on contract basis. The thing is I have

never shared my story with anyone. This is the first time I have felt safe to open up and share my problems with other people. The problem, is people are untrustworthy. But I have one friend who is also HIV positive and we sometimes give each other advice about the disease. We encourage each other not to die by taking our medication and using condoms. But my story is very painful. But I don't know why?

3.2.4.1 The participating team's reflections on Mainini Shupi's story

Mai Chipo

Your whole story is very touching. What I can relate to is that you are married; your husband didn't pay lobola just like mine. You don't have children just like me. Life for a woman is not easy. But what came through for me is the fact that, no matter how difficult life is you are working and taking care of yourself. Yes, you have never shared your story because you think people are untrustworthy but now we all have one another. We can care for each other and encourage one another. Being together like this has been the best thing for some of us ever since we came into this predicament. I now find myself every time looking forward to these meetings. I thank you all for being there for all of us.

Mother

When I look at you I see you like my own child and my heart has been touched by your story. What I relate to mostly is the way you are being treated by your husband. It must be very painful. I went through the same. Inside of you, you know that this man gave me the virus and yet he blames you for it and doesn't want to be tested. However don't give up on him. Continue to talk to him about getting tested before it is too late. Maybe our government needs to get involved in this issue of husbands who refuse to go for the HIV tests. However from your story I realize that you are a very strong young woman who has been through a lot and with that courage you will be able to encourage other young women who maybe in the same predicament.

Mukoma T.J

Your story is very touching and it makes me feel bad as a man who has acted very irresponsibly. Your story has helped me realize how unfair and disrespectful men can be to their wives. It

makes me wonder whether there can ever be any forgiveness which can be given to such a cruel husband. I am also thinking about myself and wondering whether my wife will ever find it in her heart to forgive me for lying to her and treating her the way I did. But as for you, you are very strong and courageous.

Mukoma Tippy

Your story is very painful. And what I find intriguing in your story is the courage to remain married despite the fact that you don't have a child with this man. Maybe it must be love. Things maybe looking so bad but maybe you love him and love never fails. Continue encouraging him to go and get the test maybe one day he will listen and he will go.

Mai Paida

I find your story very touching and I can relate to it very well. My husband as I have shared doesn't want to go and get tested. He has all the knowledge about the virus but still he refuses to go for the test. I asked him the other time why and he said he was afraid that he will be discriminated by people and he doesn't like the idea of taking tablets every day. I still talk to him about the importance of having the virus detected early but he still refuses. I will not give up and I know one day he will come around. I wish the government will provide us with counselors who can visit our homes and help our husbands to see the light. So don't give up on your husband. He will come around one day.

Mukoma K.K

Your story is very painful. What came through for me is the lack of support from your mother and the idea that she might think that you deserve the disease. That must be very difficult for you. But this is the life of being HIV positive. The people you think will support you they are the ones to stigmatize you and call you names. But we count our selves blessed now because we now have this group where we can now care and support each other.

3.2.5 Mukoma T.J tells his story

I have come here today for a review. I was here two months ago. I have never met any counselors here at the hospital but I would wish to talk to someone. This is the first time to have others like me sit together and share our stories. I am married but my wife has not yet tested. I also made a mistake when I married her. I never told her my status. I think I was afraid she will refuse to marry me. That was in 2007 when we got married. I started on ART in 2008. Last month she was very sick. She had herpes. They gave her medication but she was not tested. When we went home from the clinic I talked to her about HIV and herpes being one of the opportunistic infections. She refused to go for the HIV test. She is scared.

I work as a farm manager. My wife has always supported me when it comes to my medication but she didn't know what the medication was for. She comes with me here to pick up my ARVs. Today she is here outside there waiting for me. We have two children but they are my wife's children from a previous marriage. My parents are still alive and they know my HIV status. I became very sick in 2006 and I was staying with my parents. My mother used to take me to the hospital. And when the doctor suggested that I should be tested for HIV my mother encouraged me to do it. When I tested positive at first it was very difficult for me to accept the results.

At first I felt like many people were discriminating me. At church I never told anyone. I am afraid they will look down upon me as a sinner and maybe will contaminate them. Church people think that positive people are very bad people. Even the pastor doesn't know anything and it will remain like that because they may start preaching about you. My sister in-law is the other person who has problems with me being HIV positive. She despises me and she has a very bad attitude towards me. When she heard about my status she went around telling people about it. It is very painful. Now she was telling my wife to leave me because I gave her the virus.

When my wife was sick, we went to the clinic for treatment. Then when she saw the tablets I was taking, she asked me and at first I told her she was not to take them they were for my severe headaches. I had never married before. I am almost forty years. The two children are for my wife from her previous marriage. Her previous husband died in a car accident. I met her when her husband had just died and she used to come to the farm where I am the manager, selling things. I

fell in love with her. She also loved me and we got married. Ever since we married we were not using any protection when we met on the mat. But when she became sick and I told her, she said we had to use protection. Now we are using the condoms.

Now my family is saying we must have a child. It's now a big problem. I don't know what to do. I have never had a child of my own before. I used to sleep with my girlfriends without protection that's why I got the disease but I never made anyone pregnant. Maybe it's me with a problem. I have never been to a doctor for a checkup in that area so I don't know. Now my relatives harass my wife a lot demanding that we should have a child or else she must leave me. They know I am positive but they don't want me to stay with my wife. We are happy together. I love my wife but my relatives come between us. They say I must not take care of my wife's children and they accuse her of marrying me so that I could take care of her and her children. We go to church but what can the church do about such problems? The two of us we pray to God about our problems but we haven't seen God helping us yet

Even this morning, my aunt was shouting at my wife about having children. I am a class one builder. I have built a school in Harare. I wish Farirai would talk to my wife about being tested. I know she might be angry with me about giving her the disease. I don't know what I can do for her to forgive me. I also blame myself for that. Life is very painful for me. But I want her to be tested so that she can be on treatment and live to take care of her children.

3.2.5.1 The participating team's reflections on Mukoma T.J's story

Mainini Shupi

As someone who is in a loveless marriage, I just like the way you express your love for your wife and how you want to do anything to have her forgive you, for the wrong you have done. You are also taking care of her children as well showing that you are a very caring person and loving too. You are also responsible in the sense that you want to make it right that which went wrong between you and your wife.

Mai Paida

I find it very encouraging to hear you say that, you did something wrong by not telling your wife that you were HIV positive before you married. Most men do not have such regrets. They cheat on you there in the house and they don't see it as a problem. They even go further to blame you for the virus which they know where they got it from. But with you, you admit the mistake you have made and you want to make it right with you wife. You talk of loving your wife, which I think is very important in any marriage relationship. Talk to her about how you feel and ask for forgiveness. Don't give up and one day she will be tested.

Mai Chipso

Forgiveness is not easy. I can relate to maybe how you feel about your wife. In our society men expect women to accept that they can sleep around and still come home and be loved and accepted. As a wife you can pretend not to worry about it or to care about your husband's affairs but that will be a lie. When you discover that your husband is cheating, you ask yourself many questions 'am I no longer good enough for him? Is the other woman any better on the mat than me? Is he getting more love there than from me? What is wrong with me? If you try to tell some people maybe relatives about the issue, some may even laugh at you and say that all men are like that. As long as he is taking care of the children and buying food for the house its better. He will get tired. But alone you will be wondering, why this is happening to me. Even if you catch your husband right handed and you tell him to use a condom he will tell you, "I don't use a condom on the wife I married and paid lobola for." Then there is no happiness in the home and the feared thing happens. You become sick and you try everything else and when that has failed you go and get tested. They tell you, you are HIV positive. All your dreams of living happily ever after are shattered. You see darkness. You smell death. You go home to face the monster you call husband. The person who has brought death to you and expects you to forgive him and move on as if nothing happens? No ways. There are issues here to be addressed. There are issues of infidelity, lack of trust, unfaithfulness and above all the broken relationship. How do you mend this and forgive? It's not so easy yet there must be help somewhere, where I don't know.

Mukoma Tippy

The story is very touching. I can relate to the issue of calling yourself a sinner. I also struggle with that a lot. Sometimes I find it very difficult to even open the Bible and read because I will be feeling so sinful and guilt. The church makes it worse because they talk so much about sin. They talk about those who are like us who go out and get the virus, brings it home to our spouses and children. That one sin you committed, is made a constant reminder and no matter how many times who have asked God to forgive you still feel like I haven't asked enough. That feeling of being a sinner is always present with you, no matter what. This is very difficult to deal with and I don't know how and where we can get help. There is no peace at all. There is always that feeling of being alienated from God, as if God has forgotten you and he is also discriminating you as everyone does. Where can we find peace?

Mukoma K.K

I find your story very touching and to some extent I can relate to it. What stands out to me is the way you couldn't tell your wife before getting married, that you were HIV positive because you were afraid of being rejected. That fear of being rejected and feeling like no one is going to love you anymore, is very painful and difficult to understand. This got me thinking, to say, what if we could have support services for people living with HIV and AIDS where the singles, widowed or divorced may meet and maybe start dating and maybe marriage would come eventually. Because how many HIV positive singles go out and tell their dates, girlfriends or boyfriends that I am HIV positive. I wish we could start such a support group which can help HIV positives to meet and love each other unconditionally.

Mother

Your story is a story of pain. At first when you said you didn't disclose your HIV status to your wife before you got married I felt like judging you. But after some deep thought, I asked myself what I could have done if I were in the same dilemma. Could I have told the truth and risk being rejected? That's very difficult. But I am very happy that you admit the wrong you have done and you want to work it out with your wife. Keep on talking to her and one day she will go for testing.

3.2.6 Mukoma Tippy tells his story

In 2007 I became very sick. I was coughing blood and my wife encouraged me to go and get an HIV test. On the same day when I tested positive my wife had the same test but she tested negative. We have two children both boys. I am a policeman and since I tested positive I have moved towns. Here I am still new and at work I haven't told anyone that I am HIV positive. It's not so easy. That is why I have moved here where no one at work knows me. Maybe with time I will tell them because I will need to be coming here for my treatment and I may not be feeling well and I need an off day. In Harare, I had told them I was HIV positive and we had a support group going. Every Saturday we would meet to share and encourage each other. But we would only talk about small issues like taking the ARVs without defaulting. We never shared the real deep issues we are sharing here. This is the first time I have heard people talk about their lives and not only about HIV and treatment. I find this on its own very healing. I wish we could have more of such meetings and encourage others to join.

For me, my family is aware of my HIV status. I was so sick before that everyone thought I was going to die. So when I did the test everyone was aware I had gone for the test and they wanted to know the results. I found my family very supportive even up to now. Although my family is so supportive of me, it was a big struggle to accept the results since my wife tested negative. Had we both tested positive maybe it was going to be better. I didn't know what to say where the HIV came from. I asked myself many questions but I never got any answers even now I still ask myself those questions. I wasn't expecting myself to be HIV positive. It was a shock. My wife struggles too. When we meet at the mat that's when it hits me hard because we have to use condoms. My wife says to me "you see your stories what now we have to do." Every time when she says that, I struggle with guilt feelings over and over again. But what can I do now to change the situation? Sometimes I feel like my wife has not forgiven me. But she supports me a lot. She encourages me to take the tablets she says the boys need their father, She never says she needs her husband. We haven't told the children yet. We just feel they are still very young. Maybe when they can understand we will let them know.

I go to church and that's where the biggest struggle is inside me. I am a deacon at church. The whole church looks at me like I am perfect. But inside me, I will be saying if only they knew my

problem. I really struggle with guilt feelings in church. Sometimes I try to refuse the position in church but they encourage me saying I am very good at what I do. And I don't want them to know that I am HIV positive so I just do it. Then after church I will be saying, "those holy people how they can be served the Lord's Supper by a sinner like me?" I don't know whether God has forgiven me but I always feel maybe I am not clean before God. I don't think I have forgiven myself either. I always ask why I am suffering like this.

3.2.6.1 The participating team's reflections on Mukoma Tippy's story

Mukoma T.J

The story is very touching and I am sure most of us we can relate to what you have shared with us. The guilty and guilt feelings are always present everyday especially when it is time to take your medication. For me it looks like those ARVs are a reminder of what I did to get the HIV. Guilt is always there. When you think of having sex and you use a condom it's a reminder of what happened to be in this predicament. Now the dilemma comes when you are in church and you look at all those people in church, who are happy singing, dancing and some of them looking holy. You ask yourself, what am I doing among all these holy people. I can't tell these holy people my struggles because they will want to know where I got the virus from. I can't tell the pastor because he looks so holy, it will be like defiling the man of God. And besides he might be so shocked to know that I am HIV positive. The guilt is with you everywhere. But as for you, you are very courageous. You haven't stopped going to church and you still take part in the church. Although you have these concerns but you still go to church maybe one day you will find inner peace and the guilt will be removed. Just continue to pray but don't tell the church people. Your situation will be made worse. They will reject you, isolate you make you feel like you have committed the unpardonable sin and you are the chief of sinners. They will not allow you to be a deacon anymore. Life is very difficult.

Mainini Shupi

I also struggle a lot about being clean before God. From your story I relate to this most. I find it very difficult to think that God will ever forgive me and make me feel clean enough for him when I still leave with the virus. Every day the virus is in me as a reminder of past sins. I always ask

myself how my relationship with God will be healed. Is there a chance for that relationship to be restored to its former glory when I didn't have the virus? When I pray I feel like God is not listening to me. How can a righteous God listen to an unclean and defiled person like me? The uncleanliness is made worse by using condoms when we have sex, which we never used before. It will appear like whatever comes out of me is also unclean and can never be touched or be seen by anyone. Can God love someone as unclean as me? If God cannot love me who else can?

Mai Paida

I find your story very touching. What I can relate to is the fact that your wife is not HIV positive. In other words, you are a discordant couple just like me and my husband. But the big difference is that my husband says he is not HIV positive because he has never tested and he doesn't want to be tested. Your wife tested and she is not HIV positive. It is very difficult in the marriage when one is positive and the other one is not because the one who is not will never understand the inner struggles the one with HIV goes through each day. And every time you have sex and you use the condom you feel like, you are robbing the other person of their sexual pleasure and enjoyment. And sometimes you are tempted to think that maybe the other person may feel like having an affair to fulfill those needs because at home there are these restrictions of using a condom. It's not the same. The moment you start having all these questions in your mind, you start wondering whether it would be better to set the other person free by divorce? But what will the people say? What about the children? That's when you start to realize that, the marriage relationship is in big trouble and how will the marriage survive? Life is very hard.

Mother

The whole story is very touching. What I can relate to is the idea of feeling unforgiven by the wife. I got the HIV from my husband and since 2007 when I tested HIV positive I have struggled with these feelings of not forgiving my husband. Maybe, for her it can be a bit better because she is not HIV positive but what she is struggling with most is the betrayal. The issue of unfaithfulness is very disturbing. Because for us women as wives, we will be at home most of the times not thinking of anything and believing that your husband is faithful to you and all is well. It's a big shock to only realize that, the husband you trusted and whom you love has betrayed

you. He has been with other women. He has betrayed your love and devotion. He has cheated on you and now he is HIV positive and when he is sick you are the one to take care of him. You ask yourself God what sin have I committed to deserve this? After all that I have done for this man, this is how he pays me back. That is very difficult and to think that your wife can easily forgive you it is not easy. I don't know whether it is possible to forgive, forget and move on with the marriage. For me, I am struggling with that and I don't see how I can forgive my husband for all the betrayal, the cheating and the suffering he has caused in my life. So, when you feel like your wife has not forgiven you, that feeling maybe correct. Maybe she is struggling with how to forgive you for being unfaithful to the marriage relationship. How that can be healed, I really don't know. I don't know whether it is possible. The other thing is, have you forgiven yourself of all that which you have done?

Mukoma K.K

The church is supposed to help us heal from all the guilt the shame and the unforgiveness for self and others. But the church is the most difficult place to take your guilt and shame to. I can relate to why you cannot disclose your HIV status to the church. It's like committing suicide for the second time. The first time it was when you got HIV and you didn't die. Telling the church will be the second time when you will be attempting to take your life. The church teaches about forgiveness of sin but they do not practice it themselves. They teach about the love of God but that love is not there in the church. They preach about the church being a family and they even call each other brothers and sisters but in reality they do not behave like family. When you have a problem, they gossip about you saying, let's pray for so and so she has a big problem. But what I find in you, is the courage to continue being a deacon in the church and going to church every day. Things will change the moment you tell them that you have the virus. It's better to keep it a secret between you and your wife. At least, you told your family and they are supporting you. You had the courage to tell your family which some of us do not have. Maybe you trust them to keep your secret but the church can never be trusted with that secret.

Mai Chipo

What you said about the support group I can relate to that. There are so many support groups for people living with HIV. Here at the hospital they always encourage us to join support groups which are near to us. I have also attended some of them but to be honest, they are very limited. Yes, at first after testing, when you are just new to this thing, you can go to those support groups and they can help you to realize that what has happened to you is not new and you are not the only one in this thing. The more experienced ones will help you to understand the ART and the importance of adhering to your medication. People share their experiences of what happened when they tested HIV positive. But they do not talk about the real issues of living with the virus. They do not talk about the things we are sharing here. The life issues and concerns which are so deep and so hurting which needs more than ARV drugs. The issues of broken families, broken marriage, stigma and discrimination, lack of support from family and the church. Fear of disclosure because you don't trust the people to love you unconditionally. For me, this is the first time I have felt safe and cared for enough to open up the deep wounds inside of me. Things I have struggled with since I tested HIV positive. No space like this has ever been created for us to come with all our burdens and empty them without thinking that something will happen to me or will be done to me. I don't know yet whether these inner struggles will be healed here or not but I feel we are in the right place and just sharing these deep issues to me, has meant a lot. We are in the right direction towards healing.

3.2.7 Mother tells her story

I am forty one years old. I have seven children. The last of my children are twins. They are now five years old. They are also HIV positive. I am now a widow. My husband died in 2009. He was very sick. He didn't want to be tested when I was tested in 2007. I got tested when I was pregnant with the twins. After giving birth I started on ARVs. I am fine. I take my medication. But when I tested HIV positive it was very difficult for me. Life became very painful. I couldn't believe it. What was painful is that, since I was married I have only known one husband and being a mother just staying by my house taking care of my family thinking of nothing. Then when I tested positive my husband blamed me of sleeping around and wanting to kill him with the disease.

That was very difficult for me. My husband said I had to tell him where I got the disease. He wanted me to confess to him. My life was hard and difficult even to stay together. But where could I go with seven children? From the time I tested positive, my husband moved out of the bedroom. We didn't share the bedroom anymore until he died. He was saying he couldn't meet with me on the mat anymore since I had brought the disease on myself and now I wanted to give it to him. What pained me most is that, my husband had always had a very big problem ever since we married. He always had other women on the side. Sometimes he would say he wanted to marry another wife. Sometimes he would bring the women to our house. And I would leave him like that. I tried many times to talk to him about his behavior but he would tell me to remember my position as a married woman whom he married and paid lobola for. Many times I was told to pack and go. But where could I go with all the children?

But by the time he became sick and he died, we had tried to work things out. When he became sick, I was the only one who could take care of him. I did my best. The sad thing is, he tested when it was too late. Sometimes I ask myself, why he did this to me and the children. Life is very difficult. Going to church is a good thing. It really helped me. I go to those Pentecostal Churches. I used to go to another church but it didn't help me. At church I haven't told anyone about my status. This is between me and my God. There is no one who can help me except God. I have seen God helping me. There were times when I felt guilty, dirty unworthy to be loved by my husband. No relative came to help me because my husband had said; I mustn't tell anyone about my status since this would disgrace the whole family.

There was a time when I was very angry with my husband, I developed high blood pressure. Then I had a stroke and I was admitted in hospital. It was very difficult for me. People would come to visit me in this hospital and they would ask me what was the problem and I would say I don't know. Then as I was praying God showed me to forgive my husband and I would be healed physically and spiritually. I struggled with that I don't want to lie. How could I forgive someone who had rejected me like that? How could I forgive someone who had humiliated me in front of my children? My children used to ask me why we were not sharing the same bed with my husband. I would just say anything. It was very embarrassing for me. I cried to God and he told me to forgive as Jesus had forgiven those who killed him. It was very difficult. I started praying

to God to help me forgive this man. It took me time and then I felt the big lump I had carried in my heart for many years disappear. Then I knew the bitterness towards my husband was gone. Even when I look at the twins I don't have any anger towards my husband. Slowly the stroke in my left side started to disappear and I felt joy and peace in my heart, which I had not known for many years in my marriage. Now I am fine. I can move around without any problems. I come here for X-rays and everything is now fine. If God had not helped me to forgive my husband, I don't think I could have been healed. Maybe I could have died before him and who could be taking care of my children now?

The twins are doing well. They had a very bad start in life. When they were born, they were very small. I never thought they could live. They had so many health complications and the doctors could not do much for them. When they were eighteen months, they were tested for HIV and they tested positive. They couldn't start them on ART because their weight was very low. Even now, when they are five years, they look like they are two years. But because they were so sick they had to start them on ART. When I look at them, sometimes I just say what does the future hold for my twins? Why did God bring them into this world? I really don't know.

3.2.7.1 The participating team's reflections on Mother's story

Mai Chipso

Life is very difficult for an African woman and I can relate to your story although I do not have children. We all wanted to be married and have your own home but marriage has become a death trap for most women. After having known only your husband and no one else the reward you get for being faithful is the virus. How can life be so unfair? But what came through for me in your story is that you are a very strong woman. Even when your husband moved out of the house, you didn't leave him or the children. You remained and you still took care of him when he became sick. May God bless you my sister. And now you are taking very good care of the twins all by yourself. You are wonderful.

Mukoma T.J

Your whole story is very touching. It is when you listen to such stories then you start realizing the seriousness of this disease. The unfortunate part is that, it is now irreversible. You cannot

change anything except to find a way to survive. Life can be very difficult. Can you imagine how many women are in the same predicament as yourself? Who is there to help them cope with such difficult situations? However, from your story I see a very courageous woman who is determined to take care of her children. May God help you to labour faithfully for your children until the end.

Mukoma K.K

I am really touched by your story mother. I can relate to the rejection you experienced when your husband refused to share the bedroom with you. I also went through the same when my wife was taken by another man and had a child with him. I asked myself a lot of questions. I felt rejected and unwanted. The feelings just explored my head. It's very difficult to understand. Someone you have children with and now all of a sudden they just start cheating on you, Rejection is very painful. You just feel like there is something very wrong with you and you don't know what. What comes through for me is your inner strength to carry on under such difficult conditions. You are a very strong woman mother. After what my wife did what she did to me, I found it very difficult to stay with her. Even up to now I don't think I have managed to forgive her. Keep on trusting your God and you will get there.

Mainini Shupi

Thank you so much for sharing your story with us. Your story is very touching but very encouraging as well. I can never truly comprehend what you are going through as a mother because I have never had children. But I can relate to the pain of cheated by the husband. Most women are very faithful in to their marriages. And it looks like the most faithful ones are the ones whose husbands are not faithful. Your own faith does not protect you from getting the virus if you have a cheating husband. Marriages now have become the route for the HIV infection and it's so painful. Forgiving someone who has caused so much pain is very difficult. It needs some higher power to help you. I am encouraged by your determination to keep on holding onto God and believing His word that it shall work for you. I just wish I could also have so much faith in God.

Mukoma Tippy

Life can be very painful at times. Your whole story is very touching and I cannot really understand what you went through after testing HIV positive. I cannot pretend to understand what it is like to have a child living with this disease and in your case you have twins. But what came through for me is the courage you seem to have and the determination to go on despite all that is going on in your life. I really like the faith and trust you have in your God and your understanding that only God can help you. I just wish some of us could have the same faith in God.

Mai Paida

Life for an African wife is very difficult. I can relate to your husband's reaction when you told him the HIV results. As I also shared with the group my husband up to date he hasn't tested yet. He still says he doesn't believe it's true. I have tried to convince him but have failed. And he wants us to have children and I also feel at times that I also want to have children, but I am also concerned what if he or she becomes HIV positive? Will I be able to cope? For you its better because you are here in town near the hospital and we are in the rural areas. Your story has made me think about that now. However, what stood out for me is the strength you have to go on with life. You are a very courageous woman and the faith you have in God is wonderful. Just keep it up and maybe one day they will come up with a cure for AIDS and the twins will be fine.

3.3 Reflecting on creating a caring community with the participants

During our sessions, I offered all the participants an opportunity to story their experiences of being HIV positive. In the group we were concerned about each other. Every time we met as a group, I provided snacks and tea. We showed practical love by sending each other messages on the phone during the days which we were not meeting. These forms of love and care counter some of the problem saturated stories that had ruled the participants' lives before such as stigmatization, humiliation, isolation and lack of support. I offer the following transcript to illustrate how the participants felt about being in the groups.

Mother: I do appreciate the way you care for us in this group.

Farirai: Can you tell me more about this caring?

Mother: The whole group is so caring. When you are alone in your house without anyone to share your burdens with, you just feel alone and it looks like there is no one in the whole world who cares enough to listen to your story of pain. But in this group, I have found the friendship, companion, love and support which I have never known in my life. I always look forward to our meetings. And ever since we started, I wake up every morning with hope and strength to carry on because I know I am not alone. I have brothers and sisters who love and care for me so much. I really appreciate what you have done for us Farirai and I wish when you are gone we will continue meeting and reaching out to others who are where we were.

One of the most remarkable and tangible dimensions of African spirituality relates to the unique notion of communality and collective solidarity that the African society exhibits in all spheres of life. This was evidenced throughout the study by the pseudonyms used during the study which were accompanied by words denoting togetherness, oneness, connectedness, relatedness and conveying respect. Words like, *mukoma* (brother), *mainini* (sister-in law), *ambuya* (mother-in law), *Baba* (father), *Mai* (mother) were used when addressing each other within the group. This is something which happened to us unconsciously and no one planned it. I was called *mbuya*, (grandmother) which in colloquial language in Zimbabwe refers to every woman old or young who works in the hospital and it's a respectful name. In this regard we developed a participatory connectedness and we all became one.

Our way of caring for each other is further supported by Clinebell (1984:350) who states that, small groups are essential and effective in caring depicting that people who distance themselves from others are cut off from the continent of humanity and no one is an island. A person remains a person as long as he/she is with other people. Hence, there was a profound sense of interdependence from the extended family to the entire community. In a real sense, everybody is interrelated, including relations between the living and those who have departed. Clinebell (1984:353) contents that, "the group climate of interdependency facilitates the growth that comes when one becomes an agent of healing in the lives of others, even while one's own healing is being nurtured by others." In the study, I observed that people sharing the same crisis or problem because of their similar experiences, they can easily relate to each other. The truth of stories

people shared did not only teach them about others but also taught them about themselves as well. Clinebell (1984:353) refers to this as a way of releasing the potentialities that are dormant in most people when he states that, ‘in effective counseling or group counseling, the group as a whole becomes an instrument of healing and growth.’ People who participate in group therapy may be used to reach out to other people living with HIV and AIDS who are afraid and the following incept from one of the participants in the study illustrates this point.

Mai Chipo:

The lady I am working for is also sick. She had a problem of not taking her tablets. But for her she goes to a private doctor she doesn't come here. I am the one who encouraged her to go for TB and HIV and AIDS tests. She went and she tested positive. I shared with her that I was also HIV positive and I have been on ART since 2007. She was surprised because I look fit. She has now accepted it but she was scared to tell her husband. I told her my own experience of how I told my husband since I tested first. At first my husband was afraid, thinking that we had AIDS. But I explained the difference between HIV and AIDS. We came here at the hospital and we were taught. I also told my boss how I explained to my husband that we needed to take care of ourselves, especially when we meet on the mat. But it's difficult when you are used to a wet one and then you use the plastic. It's difficult. So from then on, she went to tell her husband. The husband, wife and child went to be tested but the husband wants to use herbs. The herbs do not agree with what we are suffering from. They eat well but the problem is in the blood. His problems are many because he is also diabetic. Now he has diarrhea and I am sure with time he will take the ARVs.

In this regard, Genrich (2004:47) describes care as involving really understanding a person's many social, personal, physical, cultural, spiritual needs and responding to them in an integrated way. But above all it simply means being there. Others call it accompanying a person or walking life's journey with them. This is akin to the African traditional value of *Ubuntu* doing whatever is necessary to care for the sick person because their sickness affects everyone in the community and in the family or marriage. Hence together people must work hard to ensure that life flows on as normal. Therefore, the importance of a support system cannot be overemphasized in view of this notion. In this regard, the participants agreed to give the group a name and each participant

became a founder member of the group known as **GWERU RUDO CHETE Association** and their motto is **Rudo runokunda zvole** (Love conquers all) (Appendix F). Each founder member was given an affiliation certificate. The group asked me to be their consultant and I gladly accepted their request. The certificates were given at our closing ceremony (Chapter Five)

3.4 Personal reflections

In what follows, I discuss my personal reflections on some issues which emerged for me as I listened to the participants' stories. These self reflections occurred as a response to questions I asked myself as the participants narrated their stories. I checked out these reflections with the participants, as the co-researchers and co-authors of the research report.

3.4.1 The problem saturated stories.

In this research journey, I allowed each participant's story to unfold freely as I avoided interpretations and prior assumptions. Therefore, the participants remained the experts of their lives by privileging their experiences. I needed to accept a high level of uncertainty and not knowing and although the work may bring me joy it was not always easy to be in that position. I felt called with the participants to help bring into being a new ethic of deep relatedness and caring which looked like an image of us all embracing each other deeply and unconditionally, standing together in a new way, caring with and being for each other at the same time bearing witness to one another. What made it work is, we stayed together. Perhaps we were on the threshold and I found myself both with more authenticity and relaxation in my unknown. There was an excitement, energy, perhaps a field of possibilities that began to surround us as we listened to the stories. One thing I noticed was that, anytime I started to probe or ask any clarifying questions, the energy went down. Anytime a co-researcher offered something from his/her own experience, which was congruent with the story being shared, the energy went up. I learnt to relax, to simply be in the stories as a listener and conversant. Throughout the research, I became aware of the fact that, we are all influenced by the stories of others and became aware of the many connections and relationships that existed. We acted as if we were, part of a pulsating web of life because we are. The images, feelings, thoughts and emotions which come to us when we are invited to listen deeply to stories of people's lives are transformative.

As the primary researcher in the study, I maintained the not knowing (1.12.1.3.11.7) position and this helped the participants to openly share their stories. I felt almost overwhelmed by the riches offered to me in these stories. I literally re-immersed myself in the stories as they were unfolding and it became very clear to me that, I could never fully understand the indescribable, unimaginable painful experiences of the co-researchers. What I could do was, to acknowledge the co-researchers as the experts of their own lives and the authors of their own stories. From the participants' stories, it emerged that HIV and AIDS is more than just a medical disease which requires a biomedical response only. HIV and AIDS affects the totality of what it means to be human hence, the need of a holistic approach to their care. From their stories, I then realized that most of us live our lives under the delusion that we are in control of our life circumstances, a delusion that can be maintained as long as nothing catastrophic occurs then suddenly it would seem like an alien agent called HIV is in charge of people's lives. The summation of the totally powerless feeling that results from this sudden invasion of one's life has been stated by the participants in this research as "upenyu *hwakaoma* meaning life is very difficult."

After listening to the stories of the participants I became convinced, that with regard to the lives of people living with HIV and AIDS, not enough work has been done to improve the quality of their lives. The fact that people living with HIV and AIDS experience unimaginably, indescribable pain calls for our attention for caring in a new way which this research quested for. I kept wondering as I listened to the stories, are the structures that surround the lives of people living with HIV and AIDS providing the adequate care and support that people need to improve the quality of their lives? People living with HIV and AIDS, live in a multi-cultural and multi-religious country, at a very specific time in the history of Zimbabwe, "when old habits are hard to break and hope is still fragile¹⁵⁴." In the gap between breaking old habits of caring for people living with HIV and AIDS and finding ourselves in a new era, there is a need for more research to find alternative ways of caring for people living with HIV and AIDS, considering the complexity of problems HIV and AIDS has caused on the people. Hence, this research journey was an attempt to bridge the gap by first identifying the spiritual problems and needs of people

¹⁵⁴Ackermann 2001:63)

living with HIV and AIDS and then explored how their spiritual needs could be addressed within the PHC delivery system.

On the other hand, what I realized after listening to the stories was that there is a great need therefore, for an understanding of the experiences that people living with HIV undergo from their perspective in order to come up with appropriate interventions which address their needs in a culture sensitive manner. However, when it comes to availability of literature on the experiences of people living with HIV and AIDS, spiritual needs are missing and yet such experiences are essential and as such, the study was an opportunity to highlight such experiences so that appropriate care can be implemented and people living with HIV can be empowered and healed.

3.4.2 HIV and AIDS education

Generally, I observed that the patients were properly educated about HIV and AIDS and how to take care of themselves. Those on ART seemed to know the drugs they were taking by name and their side effects. I was stunned by their knowledge. I am convinced that the medical team in charge of the O.I clinic at the hospital is doing a remarkable job. Their effectiveness and expertise is evidenced by the high level of knowledge the people living with HIV and AIDS have on the disease and treatment. The people living with HIV and AIDS are able to transfer this knowledge to others. However, this research wanted to show that the person living with HIV and AIDS needs more than the biomedical knowledge of the disease and treatment. As evidenced in the stories of the participants, HIV and AIDS affects the totality of what it means to be human. Specifically, this study focused more on the spiritual problems and needs of people living with HIV and AIDS and they shall be discussed in Chapter Five.

3.4.3 HIV Testing

All the participants related that, it took them a very long time after getting sick to go and test for HIV except for the two women who were pregnant and had no choice because it was mandatory for them to test for HIV as they attended the prenatal clinic. It seems like no one just voluntarily went for testing and I just wondered why. I wondered why the participants would wait for a long time until they were sick to test for HIV? And for the other women, I wondered why they waited

until they were pregnant to get an HIV test? Then I wondered how effective are the prevention messages which are always being taught to the people, if people can only test after they become so desperately sick that nothing else can help. Hence getting an HIV test becomes the last resort. I genuinely wondered why they took so long before they got tested after getting sick when they knew so much about the disease. Could it be fear of the disease or the fear of living an HIV positive life? I think this calls for more research to be done in terms of why people do not volunteer for the HIV testing unless they are seriously sick. I also think that there is need to evaluate the current HIV and AIDS prevention strategies for their effectiveness within the cultural settings of a particular people.

In Zimbabwe to prevent or fight the HIV pandemic the methods used have been borrowed largely from the Western medical practice. The argument is that, there is need to combine such attempts with the indigenous knowledge systems so that there is an integrated and sustainable approach. Indigenous knowledge systems in Zimbabwe are largely ignored in the HIV and AIDS discourse since AIDS had its first victim in 1985 as if there is nothing indigenous knowledge systems can provide to address a contemporary problem of HIV and AIDS. For example, there is stimulating and enriching wisdom in the Shona proverbial lore that are significant in influencing contemporary notions of infidelity and behavior change which in them can reduce the prevalence rate of HIV and AIDS. The beauty of the Shona proverb lies in its applicability to different contexts and times. The advantages of using such indigenous knowledge systems are; they are home grown, contextual, easy to grasp, open, flexible, dynamic and sustainable

3.4.4 Shona marriages in the context of HIV and AIDS

The fact that all the participants in the study are in heterosexual marriages and claim to have been infected with HIV within their marriages intrigued me to reflect on the institution of marriage within the Shona culture. Marriage as a social institution is designed among other things to ensure the happiness and fulfillment of those who contract into it. It is viewed as a sacred and permanent contract between a man and a woman who have consented to live a life of fidelity and caring for each other for the purpose of their mutual growth and welfare throughout their lives. The fact that two people consent to live together as husband and wife implies different hopes and expectations, some of which might be fulfilled, while others remain

unfulfilled. I therefore, find the dynamics of marriage institutions as a subject of continuing interest to the counselors and care givers especially in the era of HIV and AIDS bearing in mind that human sexuality in Africa occupies the central part of human life. It is above anything else and yet it is a subject which is barely discussed openly. The institution of marriage has become a safe haven for HIV and can be described as the silent partner in marriage. We need broader social, cultural, religious, political and economic policies to improve the lives of women and families within the HIV and AIDS pandemic. In the next section, I will reflect on some of the issues within marriages which I found very intriguing and worthy to take note of within the dynamics of marriages in the context of the HIV pandemic in Zimbabwe.

3.4.4.1. Marriage and the gendered HIV transmission

All research participants were involved in heterosexual marriages/relationships and they all cited their source of infection as their husbands or girlfriends. **Amai Chipso:** *My husband gave me AIDS.* **Mukoma Tippy:** *I got it from my girlfriend.* Hence gender inequalities may have greater implications for the spread of HIV within marriages. Below, I reflect on the impact and effects of male supremacy and male sexuality in marriages within the HIV pandemic.

3.4.4.1.2 Male supremacy and male sexuality

Infidelity represents a betrayal of the special sexual relationship that married people should share and it appears as if marriage equals monogamy is costing women their lives because of the male supremacy which is culturally defined. The behavior that puts women at greatest risk for HIV infection is unprotected sex within marriage and the women in this study related to that fact. Married women's HIV risk denial, combined with persistent gender inequality may have greater implications for the spread of marital HIV. From the participants' stories, men's sexual behavior presents a public health problem. To suggest that we can help married women protect themselves by empowering them to negotiate for condom use is suggesting that we can change the outcome of gendered inequalities in power, without doing anything about the actual inequality. The point I want to make here is that, the role of married men in sustaining heterosexual transmission of HIV has been insufficiently explored. The ideology of monogamous compassionate marriage may put married women at particular risk and that culturally specific economic and emotional

context of sexual relationship can provide important insight into the avenues through which gender inequalities, combines with economic organization and emerging ideologies of marital love, to put women at risk of marital HIV transmission. The needs of married women, who cannot practice abstinence, cannot control the faithfulness of their husbands and find it difficult to negotiate condom use, need to be addressed within the HIV pandemic. HIV, as the silent partner in marriage is a reality check. Blatantly put, male infidelity may certainly have wounded women especially in marriages as the following participants pointed out.

Mai Chipa: *He gave me AIDS.*

Mother: *You have to depend on this man for everything. He pays the school fees for the children and he buys food for the house. You don't question where he walks, how many women he has outside for the sake of the children.*

Mai Paida: *As a woman, I cannot tell my husband to use a condom and I cannot tell my husband not to have sex. When he wants sex I must give it to him to avoid problems in the house.*

3.4.4.1.2 Shona women and the feminization of the HIV epidemic

All the women in the study claimed to have had only one sexual partner and this is in line with previous researchers on HIV transmission in heterosexual relationships, which state that 60-80% of African women with HIV had only one partner. Bamett and Whiteside (2006:199) still in the same line of argument state that, it is a fact not repeated enough that 90% of women who have been infected with HIV have only ever slept with one man in their lives, their husbands. Hence, it was confirmed in this study that women are mainly exposed to the HIV and AIDS pandemic through the actions of their husbands or sexual partners. Therefore, the need for intimacy in a marriage relationship which is pleasurable and observes the sexual rights of people must be respected, protected and fulfilled.

The other reason for the vulnerability of women to HIV transmission is maybe the result of the patriarchal nature of the Shona culture, which allows men the freedom to have more than one sexual partner whilst women are expected to be faithful to only one person that is the husband. The most vulnerable groups of women are those who are poorly educated women, those from rural backgrounds and women who are economically dependent on men. Lower levels of

education, taboos associated with the discussion of sex, sexuality and sexual health, the submission role of women in a relationship and male control of decision making regarding sexual relations might explain why many married women are HIV positive as might be the case in this study. Dube (2003:94) allures that,

How can we expect girls who grew up under the leadership of a father, a male principal, a male village leader, a male member of parliament and a male president to believe suddenly in their capacity to lead or in the leadership of women?

3.4.4.1.3 Late marriage

Mukoma T.J's (3.2.5) story intrigued me to reflect on the issue of late marriages and its impact within the HIV pandemic. Late average age at marriage is another factor contributing to the spread of HIV because late marriage may lead to a long period of premarital sexual activity. Throughout the developing world, marriage is the central social institution that regulates and sanctions sexual behavior. This suggests that age of marriage and sexual behavior before and after marriage could play a role in the spread of HIV. There is need for more research to verify this fact.

3.4.4.1.4 Lobola in Shona marriages in the context of HIV and AIDS

Two of the women in this study (Mai Chipu (3.2.1) and Mainini Shupi (3.2.4) pointed out that their husbands had not paid *lobola* (bride prize) and now they had infected them with HIV. I just wondered what was the significance of the unpaid *lobola* to the HIV infection? Could they have felt differently about the HIV infection had the husbands at least had paid *lobola*? Muzvidziwa (2001:154) is of the opinion that while traditional Shona marriage has undergone many changes over the last 100 years, an important principle that has survived the test of time is payment of the bride prize (*lobola*) and it appeared as if a woman for whom *lobola* has not been paid is, according to Shona culture, not a legitimate wife but one of whiling up time. Mandizvidza (2001:154) further argues that, a woman to whom *lobola* was not paid for is not respected by the husband. Hence, *lobola* is an indicator that the husband values his wife. For the woman to have *lobola* paid for, means to be valued, respected and appreciated for her contribution by both her parents, in-laws and husband, It also gives a woman a sense of self worth. It also shows the

husband's complete acceptance of the wife, his total love and commitment to her. I just wondered whether these were some of the issues the women in the study were also struggling with. Could it be that Mai Chipu and Mainini Shupi felt unvalued, disrespected, unappreciated, unloved and not committed to by their husbands as they didn't pay *lobola* for them and now the husbands infected them with HIV? However, I want to argue that abuse of the custom on the hand has detrimental effects on marriage. Commercialization and overcharging may lead to the wife being treated as a piece of tradable property and what will this do to her human dignity especially in the context of HIV and AIDS?

3.4.4.1.5 Child bearing in Shona marriages and HIV

Mai Paida (3.2.2) in this study expressed her desire to have another child although she indicated that she already has other children. As I reflected on this I realized that HIV positive women have desires of having babies despite having full knowledge of their health conditions and I wondered why. Gambrone (2003:83) came to the conclusion that children are a source of strength to HIV positive women. If this argument is true, therefore collaborative partnership between family planning, HIV and AIDS services and HIV counseling as part of the integrated system becomes imperative in providing early intervention services, which will relieve the anxiety about reproduction in an HIV infected woman as well as to reduce HIV transmission and break-up.

In Africa and Zimbabwe, in particular child bearing is considered as a means of redeeming a woman's relationship with her husband. It is also viewed as a way of, protecting her against the risk of rejection, abandonment and of maintaining recognized status as a wife and mother. A childless marriage is viewed as having lost its meaning and is not perfect without children, since children are to continue the lineage of family history. In most situations a childless couple is not considered as truly married until a child is born simply because a woman is truly accepted by her in-laws only after she has given birth to especially a male child. In Zimbabwe marriage is understood as a union and bond between two people of the opposite sex. Heterosexual relations are often prized over homosexual ties for their procreation capacity that often consolidates the bond, not only between couples but also their families. In addition, procreation is significant since in the Shona culture one's own being is believed to be immortalized that is, the person does

not live only in the present but in the future¹⁵⁵. The family name is perpetuated and the link between ancestors and the living is assured with children. Therefore, the genealogy and identity ultimately die off if there are no children. In view of this, a childless marriage is considered a misfortune or a curse from the ancestors or God. This is because procreation is not only a profound function of marital relationship but guarantees societal regeneration to ensure its continued existence.

In the case of HIV and AIDS pandemic, it is critical that a new strategic plan for HIV positive couples is given extensive counseling on the use of reproductive technologies such as sperm insemination. Relationship- based risk reduction interventions, which encourage collaboration, must address mutual needs of the couple. These interventions also enable couples to gain a more realistic appraisal of their risk for HIV as a couple.

3.4. 5 Infidelity and the Sexual Offences Act in Zimbabwe

In the present study, what I also observed as we listened to the stories is that all the women in the study got the HIV infection from their sexual partners but no-one had taken any legal action. I just wondered to myself whether they were aware of the Sexual Offences Act 2007 Section 15 which criminalizes deliberate transmission of HIV, which carries a maximum sentence of up to twenty years. This law has gained ground in the criminal courts of Zimbabwe in cases of rape crimes, where the offender passes on the HIV to the victim. According to the act, one must prove that he or she knew about his or her HIV status and did not take any precautionary measures to protect his or her partners

Hence most married Zimbabwean women get infected and suffer silently because by and large, the power relationships between husband and wife in an African marriage regardless of the Act under which the union is constituted, bestows upon the husband almost total power and control over his wife. Hence most women now consider being married to be the biggest HIV and AIDS risk factor in their lives. In their situations, they cannot protect themselves as was the case with the women participants in this research. In a study conducted by Muzvidziwa (2001:157) in Masvingo Zimbabwe, regarding the concerns about the changes posed by informal marriages

¹⁵⁵Gonese (1999:20)

(mapoto) in the light of the HIV and AIDS pandemic, the women of Masvingo believed that they had better control of their bodies in these informal relationships than women in formalized marital relationships. A woman was in a better position to insist on safe sexual practices. Muzvidziwa (2001:154) adds that formal marriages have the potential of exposing wives to HIV and AIDS infection because of the fact that the rights and obligations of married persons make it hard for parties to insist on safe sex, which could have been the case with the women in the study.

3.4.5.1 The virtue of faithfulness

In the Shona culture, a married person is expected to be faithful to the spouse although polygamy is allowed. This moral expectation is captured by the Shona proverb “*zingizi gonyera pamwe maruva enyika haaperi.*” Translated to say, “insect suck nectar from one flower, the flowers of the world cannot be exhausted.” The insect was being commanded to stick to one particular flower. This analogy of the insect when applied to human sexual behavior entails that; one should be faithful in the partnership of marriage. Faithfulness is very important since it reduces the risk of HIV and AIDS considering that 99% of HIV infection in Zimbabwe is transmitted heterosexually. Urbanization due to employment and a rural home has created a dualization of homes among married people in Zimbabwean society whereby, the husband stays in town and the wife stays in the rural areas. This in turn, becomes a driver of the HIV and AIDS due to infidelity by one of the partners. Love triangles between sugar daddies, the prospective younger man and young girls, hence the proverb becomes very significant in giving moral advice in the face of the moral dilemmas. Common outcomes of infidelity are lack of trust, suspicion about unplanned absence, insecurity and uncertainty that can lead to violent possessiveness and confusion, intense guilt about the broken covenant and emotional chaos to the marriage relationship is greatly imparted.

3.4. 6 Divorce within the HIV pandemic

Furthermore, after listening to the women in the study telling their stories of unimaginable pain and suffering within their marriages, after their husbands infected them with HIV, I realized that infidelity did not terminate the underlying marriage contract. I found myself reflecting on the

following questions, why are they still married? What were their reasons for remaining married? Was there still marital hope for them or not? Is it because the Shona people perceive illness, death and marriage as having considerable influence on the way the women tended to cling on to marital hope? This Shona thought came to mind, remaining single or being divorced was seen as resulting from bad luck due to evil spirits or failure to appease one's ancestral spirits. Hence, it is important for a person to continue holding onto marital hope as a sign that one had not accepted the dominance of bad spirits and bad luck as determinants of one's life. For women marriage remains an important indicator of female status and many women believe that an unsatisfactory marriage or a brief one is preferable to, not being married at all. What could be the stigma of divorce within the HIV pandemic? I am convinced that there is need for more research to be done in this regard.

3.4.7 Discordant Couples

In this study only one participant stated that although he was HIV positive his wife was not and therefore, they are a discordant couple. I realized that there is very limited literature on discordant couples and their experiences within the HIV and AIDS discourse and most of them are hidden to researchers and health care providers. I became curious to find out more from Mukoma Tippy about his experience as someone who is HIV positive in a discordant relationship. Below is an incept from a one on one conversation I had with him in this regard.

Farirai: Can you explain to me how it has been like for you and your wife to be a discordant couple?

Mukoma Tippy: It's very difficult for me and I don't know whether I can explain it. It's all pain and suffering. It is that pain you feel in your spirit and no medication can take it away for me.

Farirai: How do you mean?

Mukoma Tippy: What I mean is there is no peace in the marriage. Things between me and my wife are not good. There is a war of words everyday but most of the times I keep quiet because I am the guilty one.

Farirai: The lack of peace you mentioned did it start after you tested positive or before?

Mukoma Tippy: We have always had problems in our marriage but I think we never really took them seriously. For me I just thought women are a problem, so it will be fine with time. But sometimes the issues used to get to me and maybe in trying to get some release from the problems at home, I made a wrong choice. The marriage was not so stable and now when I tested positive, things really got out of hand. My wife could not talk to me for weeks. She could not even sleep in the same bed with me. She despised me. I felt unclean, unwanted and unloved. That hurt me so much. And up to now I just feel like my wife has not yet forgiven me for what I did to her.

Farirai: What do you mean by that?

Mukoma Tippy: I cheated on her. I betrayed her trust. My wife was always at home taking care of our home and children when I would be working far away from home because I am a policeman. Then I started having an affair but it's not like I was very promiscuous. It may have happened maybe once or twice. That's why I really struggled to accept the results of the HIV test because I wasn't expecting a positive result. That lady never told me she was HIV positive. Maybe she was already on treatment and never disclosed to me and I got the HIV.

Farirai: How was this for you?

Mukoma Tippy: I hate myself. I regret what happened between me and that lady. I blame myself for having that affair. I have this inner battle within me and so many questions without any answers.

Farirai: Such as

Mukoma Tippy: Such as why did I do it? Why did God allow this to happen to me? I know some of my friends who have been on this game for years and with many women but they are not HIV positive. Why me? Why does God hate me so much? I know I had sinned but did that warranty such a heavy penalty? And then my wife is not positive. To me this means she is the saint and I am the sinner. Her HIV status is a constant reminder to me of my guilt and shame. Every time I want to have sex with her, she does not like condoms but what can we do? She comments that, "do you see what your stories are now causing us to do in this home?" And when I take my medication, she reminds me that I have to take them so that I don't die, the children

need their father. She never says she needs me. I always wonder whether we still have a marriage or we are just staying together for the sake of the children.

Farirai: Can you tell me more about your marriage relationship?

Mukoma Tippy: Our marriage relationship is at stake ever since I tested HIV positive and I don't know how it can be mended?

Farirai: Is that what you want?

Mukoma Tippy: What I would want is for my wife to forgive me, to talk to me, to respect me as she used to do and to accept me as I am now. But above all, I just want her to love me just as I am now. Maybe it is too much to ask of her, I really don't know if I were in her position how would I be treating her?

Farirai: You have said what you would want your wife to do for you. I am curious to find out what you would want to do for yourself in connection with this relationship?

Mukoma Tippy: What I would want to do for myself is to be able to forgive myself. I want to feel that all the guilt is no more there. I want to know that God has forgiven me but I don't know how to do that. I have tried and tried but the things continues coming up. I really don't know. Maybe if we were both positive things could be a bit better. I don't know.

Although in my mind I could never comprehend Mukoma Tippy's dilemma, I just wondered what programmes should be tailor made to suit the discordant couples?

3.4.8 Condom use and attitudes towards condoms in marriage

Condoms are provided as one of the primary prevention methods for HIV infection because they can prevent pregnancy and reduce the risk of HIV and AIDS, sexually transmitted infections. Both males and females as participants in the study thought that; condoms decreased pleasure during sex, took the fun out of sex, got in the way of sex, prevented flesh to flesh contact, condoms are too hard to use and they reduced intimacy. They thought condoms were unnatural and that they were a waste of sperms and free condoms are unsafe. **Mai Chipso** stated: *If you are used to a wet one. It's difficult when you use a condom.* Both men and women concurred to this

stressing that having sex with a condom is less natural and less pleasurable. Women saw unprotected sex as the most intimate kind of sex and some argued that, if a man was going to use a condom, he should use it with his other partners. Hence there is need to increase women's condom negotiation skills,

However, with the dominant logic of globalization, which tends to import goods and services baked in the Western liberal world to all the nooks and crannies of the global society, the way HIV and AIDS was presented and the solution offered were problematic, especially when what is recommended as a solution goes contrary to the identity of the people. It is therefore, important that there should be co ordinate efforts from both the local and the global community. Collective action should be regulated by the principle of solidarity, which calls for compassion for the needy and the principle of subsidiary, which objects to any solution that does not respect the autonomy of a particular people.

Solutions such as the use of condoms constitute problems since no effort is made to bridge the gap between the “out there” and the “here with”. The use of condoms promotes a kind of *ad hoc* solution to a problem that needs a holistic approach. Condoms are advocated for without making reference to the cultural values and traditional hermeneutics that inform the moral life of the people. The consumer culture that globalization tends to promote, overly contradicts and paralyses cultural productivity of wholesome efforts that are made to halt the spread of HIV which are essentially life giving. The limits imposed by globalization with respect to the cultural context of the African communities, make it imperative for the PHC in Africa and Zimbabwe in particular to supplement the help that comes from globalization with pastoral care, which takes the African realities into perspective. Hence, Africa needs globalization with a human face.

3.4.9 HIV status disclosure

I reflect on HIV status disclosure with regard to family, community, society at large and the church as indicated by the participants in their stories.

3.4.9.1 HIV disclosure within the family, community and society

One of the outstanding features of Shona life, which also determines to a great extent the behavior of the individual is the emphasis placed on the family unit. The Shona family is a strong

closely knit unit with a powerful magnetic pull, drawing each one into its bond. The family bonds are understood to include the spirits of the living dead. The sense of community is best expressed in the use of names in Shona culture. Individual names are rarely used. Instead, persons are addressed by relational titles. For instance in the study the participants preferred pseudonyms with relational titles like *mukoma* for men meaning, brother and for women they addressed them as *Mai* meaning the mother of so and so. Even husband and wife would use titles in talking to one another. It can be extremely offensive to call a married woman by her individual name. One's reality rests upon family relationships. It is with this understanding that left me wondering why the participants in this study, cannot trust their families and communities for them to disclose to them their HIV status.

Furthermore, in the Shona society one can depend upon family ties for sustenance and protection. There is a felt obligation to care for family needs up to three or four degrees of relationships. When one is in need, that person expects help from the family. In this setting it is easy to understand why sin is defined as an act against the family and community. Sin is seen as damaging the collective life. It is for this reason that the crucial challenge now facing the Shona culture is not technology that can be accommodated. The primary threat is urbanization, which inherently weakens family and tribal ties and thereby undercuts the very foundation of traditional culture. Could it be then that urbanization has fragmented the Shona society to such an extent that even the nucleus family cannot trust each other in such a way that the people living with HIV cannot disclose their HIV status to their children even when the children are grown ups?

On the other hand, the Shona philosophy of life is that, life is like a heavy load that one cannot easily carry by oneself and the participants acknowledged this notion throughout their stories. This realization necessitates the group approach to the challenges of life. *Upenyu mutoro* means life is a formidable challenge. Experience was the chief educator in the traditional Shona society. Can people living with HIV and AIDS be the chief educators and supporters of people about HIV and AIDS? The society and the church have failed to help the individual whose life is heavily burdened by HIV to journey with him/her and help carry the burden. The society and church as support systems have for some reasons failed to do their duty. The whole purpose of life for the Shona is to love. How can we resuscitate this indigenous knowledge system? Shona

moral thought is enshrined in the philosophy of humanness, togetherness and in that it promotes virtues such as self-control, faithfulness, chastity and respect for other people's marriages. This moral philosophy is encoded in various proverbs and since most Shona people are familiar with proverbs, it is wise to use this wisdom to address the challenges of HIV and AIDS. I am advocating here rethinking of values that were eroded as useless through the colonial process. Decolonizing therefore encourages self confidence among the Africans.

3.4. 9.2 HIVdisclosure within the church

The thought that the church seems not to care for people living with HIV and AIDS devastated me and I felt like judging them. I felt an urgent need to talk to the church into doing something. Saakvitne and Pearlman (1996:72) helped me realize that, "this work is too difficult and too personally demanding to do without a sense of mission or conviction." Hence, the aim of a spiritual and pastoral approach to healing here would be to empower the church in a transformative way which enables them to realize the need to address the spiritual needs of people living with HIV and AIDS. This is in line with the themes of feminist praxis which Ackermann (1996:36) mentions as justice, love, freedom and shalom. My assertion is that it is love which drives us to work with these themes.

The stories of the participants left me wondering why the participants did not trust the church with their HIV status and yet the church theologically, morally and contextually stands out to be the best community to contribute to the healing process of persons, families and communities affected by HIV and AIDS. Saayman and Kriel (1992:73) had already asked this question twenty years ago; "Is it meaningful to talk about healing in the context of an incurable epidemic condition such as AIDS?" I agree with Saayman and Kriel (1992:1) who stated, "We believe the answer to this question should be an emphatic "yes". However Saayman and Kriel (1992:1) go on to state, "The Christian church and other social institutions seem to be at a loss as to how to respond to the possible abyss opening at our feet." However, the fact that the Church has AIDS as purported by Dowling (2002:94) means that the church is also in great need of healing. Bongmba (2007:1) emphasizes,

The church is part of a rich human history and cannot merely stand and watch HIV and AIDS continue to kill as if its members are shielded and protected and can sing “under His wings, what a refuge in sorrow? How the heart yearningly turns to his rest! Often when earth has no balm for my healing there I find comfort and there I am blest..”

The point is that, churches by their very nature as communities of faith in Christ are called to be a healing community. Hence there is need for a greater competence in caring and counseling. Spiritual and pastoral theology is expected to recognize and appreciate the personal experiences of those suffering from HIV and AIDS and to direct them to the unconditional love of God without excluding them from the social spaces of their communities. The church ought to lay hands on the ancient writings and oral traditions that embody the origins and biography of a particular people and find out from them the settings of learning and practicing hope in the midst of suffering. The local church should enter into dialogue with the Shona culture, so as to harness those positive elements and values that are embedded in the Shona culture, such as the value of life, the sense of the sacred, the relationship between the individual and the community and love as the sole purpose of life as indicated in the Shona philosophy of life.

Furthermore, the Christian message is centred around love your neighbor as you love yourself and the Africa concept goes further than that and says, love your neighbor more than yourself. These two concepts emphasize that, we should live for each other. Families are breaking down because of the impact of HIV or rather HIV and AIDS found it's in-roads into families because of family break-down. I found myself wondering which happened first HIV or family breakdown. I challenge the church to delve deep into African in general and Shona philosophy of life and draw anecdotal evidence that shed light on the question of life as lived by the Shona people that can promote love for one another, unity, peace, order and to a large extent African human development. This is to say, the Shona understanding of human life embody a hidden genre of epistemology that could contribute in multiple ways to resolving the HIV pandemic and many other African developmental dilemmas. I argue that the exploration of the Shona understanding of life is a potential beneficial indigenous knowledge system that for long has been conceived as nonsensical and mythical by the Western civilization and yet it is one such

rich culture which can provide an answer to the multifaceted problems of the lives of people living with HIV and AIDS.

3.4.10 The power of Language

At the beginning of the research, we agreed with the participants to use Shona language during the conversations and discussions since Shona language is our first language. We were all comfortable with this arrangement although I had to do the translations myself. I shared with the participants all the translations which I did. As I reflected on this issue, I realized the language used was more life enhancing, self affirming and positive in outlook. To some extent, I want to emphasize that using the right and desirable language during communication with people living with HIV and AIDS, can help to alienate the burden of living with the disease. Although there is no Shona word for HIV and AIDS, the participants referred to it as the sickness (*chirwere*) or disease and throughout the discussions culturally familiar metaphors were used for all the terms which are considered embarrassing by the Shona people especially when talking about sex.

I realized that it is no doubt that HIV and AIDS has posted sex and sexuality in the public arena which is taboo in the Shona culture. Hence, it is taboo to use vulgar terms in public or in the presence of the respected persons, to include young children, in-laws, brothers, sisters, parents and strangers. The Shona, just like most Africans, value linguistic behavior that does not stripe them off their honour, dignity and identity. Due to unequal gender relations in culture, men are in a better position to talk about sex either in public or with their partners whist women who do so are considered as morally loose. However because of the need to combat HIV and AIDS, sex and sexuality is gradually being pushed into the public discourse. The Shona people have been forced to discuss sexual issues openly and this has been achieved through the use of hidden language or euphemism or metaphors. Hence to some extent, HIV has opened up space for a legitimized feminist discussion on sex and sexuality where both men and women can talk openly. I observed that metaphors make it lighter for people to openly discuss sexuality in a comfortable manner.

Metaphors that have been used to push sex and sexuality into the public arena include those that refer to sexual intercourse, HIV and AID itself, sexual organs and sexual relationships. The ones mostly used by the participants in the study were, *bonde*- sleeping mat which refers to having

sex, *kusangana*- meeting, which refers to having sex, *kuzivana*- to know each other, meaning to have sex, *kurara tese*-to sleep together meaning to have sex, *Kujaira nyoro*- used to a wet one means having sex without a condom. Hence the participants were able to freely and openly discuss about sex using the above metaphors. I understood the hidden meanings perfectly well and I also felt comfortable. I also used them without being disrespectful to the participants. HIV was termed sickness/*urwere hukuru* and taking ARVs was termed- *ndiri pachirongwa* meaning I am on the programme. The sexual organs were referred to by both men and women as *nhengo yababa/yamai*- father's or mother's organ. Other women, when referring to the husband's sexual organ termed it *baba*- father. **Mother** freely shared with the group that they could not use condoms at all with her husband because *baba vaiva vahombe*- father was "big" meaning, the sexual organ of the husband was quite big and could not fit into the condom.

Although to some extent I appreciated the openness of the discussions on sex and sexuality using the metaphors, I kept on wondering; does this language really help to bring human sexuality among the Shona people into the public discourse in a positive way? What is the impact of such a language in curbing the spread and stigma associated with HIV and AIDS? However considering the challenges HIV and AIDS has brought on human sexuality in Zimbabwe, it is imperative that the subject of human sexuality has to be discussed openly if the battle against the pandemic is to be won.

3.5 Conclusion

In this chapter, I narrated the stories of seven people living with HIV and AIDS receiving care within the primary health care delivery system in Zimbabwe who were the research participants. Schaafasm et al (2007:282) write, "research is the story someone gets to tell what counts is who gets to tell the story." In this regard, it is my hope that, in telling the stories of these seven people, that I do so in a way that readers gain an understanding of their experiences of living with HIV and AIDS as backdrop to understanding their spiritual problems and needs identified and discussed in Chapter four. The stories told by the participants in this study clearly indicate that HIV and AIDS is more than an infected body and it usually has to do with infected

relationships. The traumatized people suffer damage to the basic structure of the self¹⁵⁶. They lose trust with themselves, other people and God. The self esteem is assaulted by experiences of humiliation. Hence, this chapter through the stories of the participants has indicated that the people living with HIV and AIDS experience unimaginable pain and they describe their lives as being very difficult. In the narrative language, the stories of the participants reported here are problem saturated. At first I was devastated and I didn't know what to do. I then encouraged myself that "not knowing" was the best position for me to be in this journey as the participants were the experts of their lives. After giving the backdrop to the research question in this chapter, chapter four focuses on answering the first part of the research question, by identifying and investigating the spiritual problems and needs of people living with HIV and AIDS according to the participants' perspectives. This was done in the hope of developing alternative stories from the problem saturated stories told by the participants and documented in this chapter. Hence in chapter four we started weaving themes from these stories together and in the process of doing that we co-constructed new knowledges about the spiritual issues and concerns at hand. This further assisted the participants to deepen their own understanding of their experiences of living with HIV and AIDS.

¹⁵⁶Herman (1997:56)

CHAPTER FOUR

WEAVING THEMES TOGETHER: CO-CONSTRUCTING NEW KNOWLEDGE

4.0 Introduction

This chapter focuses on how the first part of the research question was answered during the research journey, as the spiritual problems and needs of the participants were identified and investigated. Through a narrative linguistic practice called externalizing conversations (1.12.1.3.11.1), I joined with the participants in researching the spiritual problem and its effects on their lives in ways that exposed, deconstructed and challenged dominant cultural narratives by which people organize and live their lives¹⁵⁷. Therapeutic questions (1.12.1.3.11.5) were also used to deconstruct (1.12.1.3.11.2) the spiritual problem and its effects. I shared the preliminary findings with the co-researchers and began to refine the spiritual issues through conversations. As they responded changes and additions were made. In some cases, I listened to the conversations and made close to verbatim transcriptions. I have used literature as a way to deepen and expand the meanings found in the different themes which emerged from the experiences of people living with HIV and AIDS. Individual one on one conversations and group discussions were supplemented by material obtained from various published sources. I continued to reflect on various themes as they emerged. The co-researchers were understood, respected and credited in order to refrain from imposing on them my own value judgments and this was aimed at acknowledging their own perceptions as the experts of their lives

It is tempting to over simplify a thesis about the spiritual problems and needs of people living with HIV and AIDS and yet the truth is, an essential part of understanding the spiritual problems and needs of people living with HIV and AIDS is to recognize that it is as complex as the disease itself. Researchers in general love to label, categorize and to diagnose as a way to reduce the infinite variety of human experience into segments that seem graspable, knowable and even fixable. Accordingly, together with the co-researchers, we decided to make a list of the main themes in general and the major spiritual issues in particular which the participants experience as people living with HIV and AIDS. These are the variables that determine the unique personal

¹⁵⁷Morgan (2000:46-47)

shape of the disease's shadow on their lives. I am convinced that, only through the processes of understanding and harmonizing their individual circumstances can that shadow be lifted and healing occur. The ones presented in this chapter began to emerge.

I make no claims to the discovery of ultimate truths in terms of identifying, investigating and understanding the spiritual problems and needs of people living with HIV and AIDS. The contextual nature of the participants' knowledges makes it impossible to voice large truths. All we could do is, to voice local truths and propose that it pertains somewhere. Hence, the uniqueness of this epidemic among a particular people makes it imperative for us to engage in a contextual understanding and appreciation of this problem within the cultural, political, spiritual and social situation of Zimbabwe. In this regard, the spiritual problems and needs of people living with HIV and AIDS were discussed against the background of the Shona Christian worldviews and beliefs as well as the scientific biomedical worldview and their interconnectedness to illness and healing. Hence, the next section discusses the success story of Anti-retroviral therapy (ART) in the management of the HIV infection as articulated by the co-researchers and where necessary incepts from the conversations are used to illustrate the point. It is against the background of the successes of ART that the spiritual issues, problems and needs the participants emerged.

4.1 The success story of Anti-Retroviral Therapy (ART)

The benefits of ART have been widely documented with effective management of persons with HIV infection; it is possible to delay the onset of AIDS defining illnesses and to provide a high quality productive life. ART consists of treatment by the administration of drugs that attack the HIV itself. These drugs interfere with the manner in which, the virus tries to reproduce itself inside a human cell although ART drugs cannot destroy the virus completely. According to the Zimbabwe National AIDS Council (2011:22) there are three classes of drugs used in Zimbabwe which are; nucleoside reverse transcriptase inhibitors and the following drugs are in this class, zidovudine (azt), didanosine (ddI), zalcitabine (ddc), stavudine (d4t), lamivudine (3tc) and abacavir (ABC). The other class is non-nucleoside reverse transcriptase inhibitors which contains the following drugs, nevirapine (nvp), efavirenz (ffr) and delavirdine (dcv). The third class of ART drugs is protease inhibitors and the drugs in this class are; saquinavir (sqv), ritonavir (rtv),

indinavir (idv), nelfinavir (nfv), amprenavir (apv) and lopinavir/ritonavir. There are other classes of ART drugs such as nucleotide reverse transcriptase inhibitors and fusion inhibitors.

According to the Zimbabwe National AIDS Council (2011:37), HIV infected people start on ART when the prognosis of the infection has reached WHO stage 4 irrespective of CD4 cell count and when they are at WHO stage 1, 2 and 3 with CD4 count below 200 and that is when CD4 testing is available. If CD4 testing is unavailable, total lymphocyte count (TLL) and WHO stage 4 irrespective of total lymphocyte count as well as WHO stage 2 and 3 disease with a total lymphocyte count below 1200 can be used to determine the starting of ART. The first line treatment for adults living with HIV in Zimbabwe is, stavudine 30-40mg orally twice daily plus, lamivudine 150mg orally twice daily plus niverapine 200mg orally daily for two weeks and then 200mg orally twice daily¹⁵⁸. Alternative first line treatment for adults would be, zidovudine 300mg orally twice daily plus lamivudine 150 mg orally twice daily plus nevirapine 200mg orally daily for a week and then 200mg orally twice daily thereafter¹⁵⁹. The treatment regimen may need to be changed, if there has been treatment failure or if the patient is unable to tolerate the drugs due to toxicity and specialist opinion will be needed first. In the event of treatment failure, patients that fail to respond to first treatment should be treated with a different regimen that contains drugs that were not included in the first regimen.

The ultimate purpose of ART is to reduce the HIV viral load (viral RNA levels) to below the level of detection (or at least as low as possible).as much as feasible preferable to undetectable levels (<25 cells/ml- for as long as possible)¹⁶⁰, restoration and/or preservation of immune function, reduction of HIV related morbidity and mortality improvement of quality of life. Medication is taken every day and compliance with and adherence to, the treatment regiment is mandatory.¹⁶¹ It should be noted that, ART is required for life in persons with HIV infection. Therefore compliance and strict adherence to treatment regimens and schedules is necessary. The indications for ART have undergone dramatic changes in recent years and recommendations for their use remain in flux.¹⁶² ART cannot cure HIV, but it can control the disease by reducing the

¹⁵⁸ National AIDS Council (2011:37)

¹⁵⁹ National AIDS Council (2011:22)

¹⁶⁰ Spencer (2005:4-13), Van Dyk (2004:67)

¹⁶¹ Spencer (2004:67)

¹⁶² Van Dyk (2004:67-73), The Foundation for professionals development (2004:175-221)

viral load, followed by immune reconstruction¹⁶³. The limitations of ART are incompetence potency, drug toxicity, drug interactions, drug resistance, adherence and cost. The pursuit of an AIDS vaccine remains a critical international goal. However, the fact is that with the success of retroviral drugs many of the infected now live healthier lives and have a higher quality of life which indicates that they are now more concerned about life than dying. The research participants reflected on and consolidated this fact.

Mainini Shupi

Before I started on ARVs I was very sick. I went everywhere looking for help but nothing helped until I came here at the hospital and after testing HIV positive I started on ARVs. Now I am fit. These tablets are very strong and they work I now know I will not die of AIDS. I will only die when God decides.

Mukoma Tippy

I was dying. Nothing seemed to help with what I was suffering from. Then after testing HIV positive I started on ARVs so now I am in the program (ndava pachirongwa). I look fit and it's now five years since I started on ART. If I don't tell people that I am positive no one can tell by just looking at me.

Mukoma T.J

Had they not put me on ART I could be dead by now because I was very sick. I didn't know what the problem with me was. The prophets couldn't tell. The traditional healers (n'angas) said what they said. I did everything they said I should do but nothing helped. Nothing could help me. Until I came here and it was after testing positive that I started on ART and immediately I was well. It is now eight years since I started on ART.

¹⁶³ Isselbacher et,al (1999:1473), Gerberding and Sande (1999:1470)

According to the guidelines of WHO¹⁶⁴, on the use of ART, mortality has dropped significantly worldwide including in Zimbabwe. I am convinced that great advances have been made in the treatment of patients with the HIV infection. However, it is also my understanding that HIV management is supported by many pillars such as lifestyle changes and support, treatment and prevention of opportunistic infections as well as ART. However, the treatment of patients with HIV infection requires not only a comprehensive knowledge of the possible disease process that may occur but also the ability to deal with the problems of a chronic potentially life threatening illness¹⁶⁵. I also assert that the patients must be educated, concerning the potential development of resistance to ART drugs, and the importance of constant and continued adherence. However, from the stories told by the research participants, it is clear that the pendulum of the pandemic has swung from dying from AIDS to living with the HIV infection; hence a primary focus of therapeutic intervention is to enhance the quality of life. The participants in the study agreed with this assertion and the following section deals with what some of the participants pointed out as the challenges of being on ART for the rest of their lives.

4.1.1 ART for life: The challenges

The management of HIV infection has become increasingly complex because of the large numbers of available drugs, drug combinations and because of the toxicity associated with drug therapy. In addition, some ARVs may not be used in combination with drugs commonly used for treating infections such as tuberculosis. Hence, it should be stated that ART is required for life in persons with HIV infection. Therefore, compliance and strict adherence to treatment regimens and schedules is necessary. It is also important to note that the viral resistance to the drugs merges readily, hence the need for continued vigilance and monitoring. On the other hand the treatment regimen may need to be changed if there has been treatment failure or if the patient is unable to tolerate the drugs due to toxicity and specialist opinion will be needed first. In the event of treatment failure, patients that fail to respond to first treatment should be treated with a different regimen that contains drugs that were not included in the first regimen. In line with this argument, the participants had this to say about the challenges they are facing, taking ART drugs daily for the rest of their lives.

¹⁶⁴ WHO (2002)

¹⁶⁵ Kasper et al (1999:1901)

Mukoma K.K

We are thankful that the doctors have found a way of keeping us alive for a very long time and we are no longer afraid of death. As long as we take the tablets on time every day and we do what they tell us to do we will be fine. The problem is, to know that you have to take them for the rest of your life. That is not easy. It becomes challenging when you go somewhere and you don't want people to know that you are HIV positive and you want to take the medication. How do you hide them from the people? It makes life very difficult. There are the side effects which are caused by the drugs which are also very challenging to deal with. For example, I started developing this big stomach when I started on ART. I also put on a lot of weight, which I used not to have before I got the infection.

Maininin Shupi

These tablets they keep us alive but they are not nice at all. You have to tie your tongue to swallow them. They are like bitter herbs. At least we know death is no longer the issue. For me the greatest challenge is when you visit relatives or you attend a funeral and they delay giving you food when it's time to take the tablets. What do you do? At the same time you are trying to keep your status a secret because you don't want people to discriminate you. Life becomes very difficult at times.

Mother

For me and my twins when it's time to take the tablets we sit together and we take our medication. I always say to myself "So it means that my boys will have to take their medication for the rest of their lives. What will happen when they want to start dating? Will they tell their girlfriends that they are HIV positive? What will happen when others at school will find out that they are HIV positive when they see them taking the drugs every day?" (Zvakangoomavo hazvo) meaning it's just very difficult.

Mukoma Tippy

We are a discordant couple. I am positive and my wife is not. She reminds me every day to take my tablets and that reminder it's like, she is also reminding me of what I did to be HIV positive.

It's not easy to take those tablets every day. But if you want to live you have no choice. My wife says, "take your medication you have to be alive for the boys. They need their father." Although I know, taking them will keep me alive but I am always asking myself, for how long will I continue taking these drugs? Life is very difficult.

Mai Chipo

I am now used to not feeling well and to tolerate the side effects of the drugs. This is also accompanied by the burden of not looking normal. I now have a bulging stomach like a pregnant woman. And some people are always asking me when I am giving birth. Even my face has changed these drugs cause a lot of changes to the body. It's not easy to be on the drugs for the rest of your life but what can you do if you want to live?

It was agreed by all the participants that ART is keeping them alive and as long as they adhere to medication, hospital appointments, good nutrition and protection they will be fine. A few years ago, the fear of people living with HIV and AIDS was on dying but it seems that their fear now is on long life being on medication¹⁶⁶. Hence, lifelong support and care becomes imperative. For example when **Mother** spoke about her feared challenges concerning the twins, I reflected on what it could be like to be HIV positive when one is a teenager and starts dating. How many HIV positive teenagers will disclose their HIV status to their dates, boyfriends/girlfriends without the fear of being rejected or discriminated? I also wondered what programmes are available for the adolescents who are HIV positive to care and support them considering, that being a teenager already has its own challenges what more when one is HIV positive? Surprisingly, there doesn't seem to be any special programmes designed for this special population in terms of caring and supporting teenagers who are HIV positive. Hence, this calls for more research and special programmes to be designed for this special population

¹⁶⁶ Ekeopara and Ekeke (2011:49) Africans believe that all people are sacred and consequently no person is expendable. Human life is sacred because it comes from God the Supreme Being. This is why almost anything could be done by the African in order to preserve life. Life is a very important value to be conserved.

4.2 The new life: A heavy burden

It is very clear that the greatest challenge faced by people living with HIV and AIDS now is on living an HIV positive long life taking ARVs daily knowing that there is no cure for AIDS. Some of the participants termed it the new life which they all described as a heavy burden. Chaminuka (2001:31) allures that in Shona philosophy of life, when a life experience is unimaginably painful and indescribable it is likened to a heavy burden which one cannot carry alone. This was a statement repeated over and over again in all their narratives by the participants in this study. I became curious and wanted to know why, they continuously described life as a heavy burden when ART has removed the fear of death from them. Stinton (2000:120) adds that life is so precious and of such cardinal value in African societies that it has become the starting point of some theologies.

Hence, (2010:87) describes health and healing as one of the primary concerns of the Shona people. In addition, Shoko (2010:87) notes that for the Shona a prolonged or serious illness is presumed to have some invisible cause. The Shona are not only interested in being cured but go further to seek the ultimate cause of the illness. When the Shona are confronted with a complicated case, the Shona concept of causation plays a dominant role. This argument can be reconciled with what the participants described as the spiritual root causes of HIV and AIDS according to their perspectives. In this regard, the next section deals with what the participants described as the spiritual issues affecting people living with HIV and AIDS of which, ART cannot deal with. That is what has made their lives a very heavy burden to carry alone.

4.2.1 Spiritual root cause of HIV and AIDS

Admittedly, ART has shown remarkable success in treating the physical symptoms of HIV and AIDS and this has been confirmed by the participants in this study. However, the Shona thought about scientific medicine is captured by Graves (1988:103-104) as follows,

The Shona realize that the skill of the medical doctor can deal with the physical manifestation of most diseases But they would go on to insist that no amount of medical knowledge can deal with the real cause of the disease itself. So a child can be treated successful with western medicine for an attack of malaria. Still western medicine cannot

answer the question, why did the mosquito bite my child? Hence people must always look beyond physical events to the spiritual etiology of the disease.

The point is, in the Shona thought, there is no such thing as an event without purpose. Therefore disease, death, a stillborn child, a fire caused by lightening are each the result of the confluence of the anger of the spirit world and the waywardness of persons. For the Shona people must look beyond the physical manifestations of the disease to the spiritual etiology of the disease.¹⁶⁷ It is strongly believed that any illness or sickness has a cause or causer and the question why the HIV has infected a certain individual and not the other must be answered. As the world continues to watch the tropical diseases and AIDS epidemic continue to wreck havoc throughout the African continent, it is to this end that this research, acknowledges the importance of harmonizing all available traditional, spiritual and biomedical resources to stop or ameliorate the spread of these deadly diseases. Consequently, in African indigenous healing systems emphasis is not on the disease but the cause hence the healing process does not target the disease but it is applied holistically as a community responsibility.

The above argument is persuasive and can be reconciled with the aim of the study, which sought to look beyond the physical manifestation of the disease to the spiritual etiology of the HIV and AIDS, which the Shona consider to be the real cause of HIV and AIDS as also articulated by the co-researchers. This is in line with what Imasogie (1993:60) describes about the African philosophy of life, “there is no event without a spiritual/metaphysical cause hence man must look beyond physical events to their spiritual etiology”. Social constructionists have no difficulty with “locally claimed realities as these may be anticipated and honored¹⁶⁸.” The locally claimed realities of people living with HIV and AIDS who are the co-researchers in this research journey in various capacities were honored by giving them a chance to speak as theologians in this academic discourse. The people living with HIV and AIDS are emphasized as the primary source of data. That means the people living with HIV and AIDS are regarded as the experts of their lives. In this regard, I became curious to find out from the participants what they considered to be the spiritual etiology of HIV and AIDS. Some of the participants had this to say in response

¹⁶⁷Graves (1988:103)

¹⁶⁸Gergen and Gergen (2003:228)

4.2.1.1 God and the ancestors

Mukoma Tippy

I was very sick for a very long time and I went to the traditional healers first to find out what was really wrong with me although we are Christians. I went with my parents and some relatives. We went to many of them, trying to find out what was the real cause of my sickness. Everywhere we went we were given medicines but that did not help at all. When we enquired about the real cause of the disease, they all pointed to the ancestors being angry with me for not following these traditional practices.

Farirai: *So what did this mean to you?*

Mukoma Tippy: *It meant that the real cause of what I was suffering from was spiritual. I had done something wrong which had angered the ancestors, which is why I was sick. And for me to be healed certain rituals had to be done.*

Farirai: *What happened then? Did the traditional healers help to make right that which was wrong?*

Mukoma Tippy: *They tried but it didn't help that's why we went from one healer to the other and here I was getting weaker and weaker physically. The last traditional healer told me that my ancestors had told him that, they really didn't understand what was wrong with me because to them, this was a modern disease and they didn't know about it. I believed this one. From there one relative suggested that I should go and get tested for HIV. I did that and I tested positive. Life is not easy and I still don't know why I have to live with this punishment.*

Farirai: *Where does that leave you now? Do you still believe the ancestors are responsible for your illness?*

Mukoma Tippy: *I am now confused. This disease confuses you. I did all the rituals the traditional healers said I should do but I was not healed and I still ask the questions why am I suffering like this? Only God knows.*

Mai Chipo

Like everyone else in our culture, when one gets sick first you must find out who did this and why? I was very sick for a long time and as our custom we visited the traditional healer who usually helps us with other family issues. Of course someone had bewitched me but that was not the reason. The traditional healer consulted the ancestors who told him that my husband had not paid the lobola and they were not happy. We tried to negotiate with them because my husband is also sick and he left work a long time ago but to no avail. And that left me with so many questions not answered. My health was deteriorating. A friend suggested that we go and test for HIV. We did that and both me and my husband tested HIV positive. We are on ART and we look fine physically. Ever since I tested HIV positive I always ask myself, why me? I have known one husband in my life. I have been faithful to one husband and I have never looked at any other man in my life. Why did I get the virus? Why me? Surely am I the only one whose lobola has not been paid in full to warrant such a curse? Why has God given me such a curse?

Mai Paida

When I was pregnant with my last child I went to the clinic for a checkup. They told me I had to test for HIV. I joined the queue without thinking about anything. When the results were out I was called into a different office than the others. The sister in charge told me I was HIV positive. I couldn't understand that. Where did it come from? My first thoughts were who did this to me and why? I am a born again Christian and my first thoughts were why God? I have observed all that you have taught me to do. I am a devoted Christian why should this be happening to me? Of course at the clinic they explained to me how HIV is contracted but that is not the root cause of the disease. The real cause is spiritual. God had forsaken me and I want to know why because this disease is terrible. You wouldn't understand..

According to Ekeopara and Ekeke (2011:44) the African society has a well defined religious culture with a definite concept and understanding of the divine. They believe in the Supreme Being (God) who is the creator, the great provider and sustainer of man in the universe. He is a God who cares for all His creation especially, when man is confronted with the various problems of life that threaten his existence. According to the Shona cosmology, the world and all that exists began with God, the Supreme Being and Creator. *Mwari* is the personal name of the Supreme Being, who is the Great one or He who is. The Shona also call God by other names

referred to as ‘praise names’ or attributes. The names are used to describe his nature and functions. They include *Musiki* (Creator), *Muvumbi* (Moulder), *Nyadenga* (Owner of Heaven) but mostly He is often referred to as *Mwari*. The Shona do not believe God to have a shape or form such as human beings but as a spirit, who inhabits heaven and who is also present on earth. It is believed that God made all and everything that exists and that He is somehow involved in the everyday lives of people. He is responsible for good but also for bad in the world and can give happiness or bring sudden destruction to an individual. It is believed that a human being cannot really reason or argue with *Mwari* and the concept of an individual living in a close personal relationship with God as found in Christianity and Judaism is therefore not accepted.

My own understanding of God is influenced by the postmodern theology that allows me the space to accept the other person’s view of God in our conversations, where every person imagines God personally and differently. Although this does not exclude the religious feeling that my God is also your God. The seven participants are Shona Christians just like me, although we all belong to different denominations. But being a Shona Christian like the participants could be easy for me to fall into the trap of the certainty of knowing what God is like for them. Griffith (1995:126) defines this as the entrapment of knowing, that comes from knowing what God is like for you because I know your religious affiliations or denomination¹⁶⁹. The participants were allowed to express their own views about their God throughout the research without being judged or condemned.

The participants confirmed that the Shona believe that the dead still have influence in the lives of the living as also observed by (Gelfand 1964:32; Idowu 1973:173). Ancestral spirits are known as *vadzimu* (plural) or *mudzimu* (singular) and these are the spirits of the dead relatives considered as the “King pin” of the Shona society.¹⁷⁰ They influence the activities and lives of their dependents, the living members of the community. Misfortunes like droughts, floods, crops failure, sickness and death are blamed on the presence of angered spirits because they have not been accorded honor with proper funeral rites. Ancestors operate at three levels namely, the family, ethnic and national levels. Mwauri (2000:79) is of the opinion that the causes of illnesses

¹⁶⁹ Griffith (1995:128) found in her research that denominational beliefs were a poor predictor of the persons experience of God

¹⁷⁰ Shoko (2004:5)

are believed to be of a direct consequence to the breaking of taboos and offences against God or ancestral spirits. In this regard, God is linked to the spiritual etiology of HIV and AIDS through the ancestors who though dead are still interested in the lives of the living. Healey and Sybertz (1996:211) affirm.

In African cosmology, the living dead are the link between the living and Supreme God. Good relationships with the living dead are extremely important and violation of them may lead to misfortunes or severe illness.

Hence Magesi (1997:20) states that the role of the ancestors is dominant because of their close association with God and can never be accused of moral wrongdoing, since they are believed to be able to control events on earth good or bad. Mbiti (1984:84) asserts that ancestors are the mediators between God and their descendents and even traditional healers operate through the mediation of the ancestors. Magesi (1997:20) asserts that ancestors are the moral police of the individual, families, clan and societies with which they are associated hence they are to be respected, remembered and revered because of their status as the intermediaries between the living and God. Shoko (2004:11) illustrate that, even in death the Shona people value the dead body much more than just a dead corpse. To the Shona, a person's dead body is sacred because the dead become more powerful after death as a material symbol of history, which reorders the world of meaning and establishes cosmic order. Hence the Shona have profound concerns about the treatment of the dead.

However, it appears as if HIV and AIDS has become scandalous even to the ancestors because no matter how many broken ties are mended people continue to die even the young ones. The participants agreed that no matter how many times they performed the rituals nothing helped them until they came to the hospital where the physical symptoms of the disease were addressed but not fully since there is no cure for HIV and AIDS. For the participants the question which remained to be answered was "why me to be suffering from an incurable disease." I became curious to find out from the participants how; they now perceived the ancestors in terms of trusting them to help them with other problems of life since they seemed to have failed in this regard. Can the ancestors still be trusted in other issues of life? To this the participants responded.

Mai Paida: *In the case of HIV and AIDS the ancestors don't know what to do because most of them call it a 'modern disease' and they have never suffered from it. But in all other areas of life yes they can still be trusted to offer advice and to heal. We still consult the ancestors on other life issue. The medical doctors have failed to cure this disease but we don't say they have failed. We still consult them on other health issues so it is the same with the ancestors.*

Mukoma Tippy: *I still go to the traditional healer to inquire from my ancestors about other life issues. It's not their fault that they have failed to cure or heal AIDS. The scientists and medical doctors have also failed to cure AIDS and we don't blame them. We still visit the medical doctors with other health complains and they successfully help you out. For me, I still trust the ancestors. HIV and AIDS has just proved to the ancestors and the medical doctors that as human beings they get somewhere and they cannot go further. They are both limited as human beings. So the answer is with God. Only God can.*

Mai Chipso: *No one can afford not to trust their ancestors. Yes HIV and AIDS has greatly challenged them as it has challenged the scientists but they have been successful in other areas. I am still consulting with my ancestors on other areas of my life. The answer for HIV and AIDS is with God and only God can heal.*

The participants made it very clear that although the ancestors cannot provide answers to why they are suffering from HIV and AIDS, they can still be trusted to help out in other areas of life. The ancestors are still respected for their role in the individual's life and the participants still consult their ancestors on other issues of life. No human person has an answer to this scourge even the scientific doctors. Louw (2000; 30) points out that, in this view all suffering can be traced to God's will or at least His permission. The AIDS patient may understand that God allows suffering and evil but is not necessarily directly responsible for it. Suffering remains an insoluble but incurable part of being human. However, this does not comfort people in their quest to find healing within the HIV and AIDS pandemic. Hence the study quested for a spiritual and pastoral approach to healing for people living with HIV and AIDS

4.2.1.2 The Witchcraft and Spirit theories

Mainini Shupi

Why did I do this to myself? Was I under a spell? Why was I cursed or I am demon possessed? One prophet told me that I was demon possessed and I needed cleansing. I went back for that cleansing but I still want to know why did the demon come for me and not the other people? Why this one was specifically meant to attack me? The pastors at church they do nothing they just say those who are sick come to the front for prayers. You go there and they just pray for you. Nothing happens. You just go back home the same with your spirit much more troubled because you will be saying to yourself, 'my case is the worst case ever. Even the man of God cannot do anything about my situation.' Outside I look well but inside, it's all pain and unanswered questions. Who can help me now?

Mukoma K.K

I never thought I would test HIV positive. Many of my friends had many girlfriends. They are not HIV positive. I am HIV positive and I never stop asking myself why me and not my friends? Why am I the unlucky one? First my first wife was taken by another man and he was policeman for a fact. And now I marry a second wife whose husband used to cheat on her. She must have brought the virus to me. Why am I so unlucky with women? Why has this spell been cast on me to allow the virus an entrance into my life? Who bewitched me and why? This disease is very terrible. Only the work of witches can produce such suffering. Only witches can allow someone to suffer like this for no cause. What have I done to deserve this? I wish I knew who the witch is and I would go and beg her to remove this thing. The traditional healers have failed on this one. They can't remove the spell of the witches in me.

The Shona people believe that, illness that are not easily treated are due to the active intervention of an agent, like a witch, a ghost, ancestor or an evil spirit.¹⁷¹ Witches in the African societies are believed to be the authors of evil causing misfortunes, bad luck and sickness. Healy and Sybertz (1996:292) reflect, "when sickness, death and other calamities are encountered, the reaction is expressed in the words, "I have been bewitched" or 'I have displeased the ancestors!" When someone gets sick, the two most frequently asked questions are 'who did this?' and 'why?' For

¹⁷¹Magezi (2005:35)

the Shona it is sickness that is fatal which is caused by the witches. Moila (2002:23) affirms, “angered fellow humans are the sources of the sicknesses which are unto death.” Unquestionably, in the African worldview, witches are perceived to be the primary causes of sickness and illness experienced by the Africans implying that to some extent HIV and AIDS can be perceived as being caused by witches. This is also supported by James (2008:14) who affirms that some communities in Kenya believe that AIDS patients have been bewitched. Healey and Sybertz (1996:233) point out.

Witchcraft is a group nightmare, a stereotype that possesses strong group values. Witches are a threat to the security of the community. They are public enemy number one. Sometimes they are called devils. Fear and reality of witchcraft is an everyday experience. The biggest felt need of Africans is relief from the effects of witchcraft.

Therefore in terms of illness ancestors are seen as having failed to protect the victim from being bewitched because they are angry with the victim. In essence, when the ancestors are angry with the person, automatically God is also unhappy with the individual.

Shoko (2004:5) asserts that the Shona believe in a host of other spiritual entities that populate their traditional cosmology and one type is *mashavi* alien spirits. These are spirits of people unknown to the Shona families who die far away from their homes, without proper burial rites. They include spirits of infants *chipunha*, white men *chizungu* and strangers from neighbouring countries such as Mozambique *chisena* and animal spirits, such as baboon spirits *shavi regudo*. The general belief is that spirits confer benefits and arts of healing, divination, singing or dance. However some can confer negative qualities like witchcraft, theft or prostitution. The Shona also believe in other natural spirits which comprise of human spirits raised from the graves such as *tokolotches* and *zvidhoma*. Some spirits like *zvitupwani* and *zvikwambo* (puppies) are associated with witchcraft¹⁷².

Mpagi (2002:216) discusses that evil spirits belong to a category of beings, which include the ancestral spirits, which have turned out to be evil and seen as allied with the devil. Evil spirits or demons are believed to live hidden among people. They hide in various ailments and diseases

¹⁷² Shoko (2004:6)

where they try to make life difficult as they can. These spirits come into the person to dwell in him/her to exercise the power of domination. In addition, Shorter (1986:111) contends that sickness in African worldview can be called a ‘spirit theory’ of disease although the germ or virus theory is acknowledged as secondary.

Rodlach (2006:55) adds that witchcraft is seen as the most potent symbols of evil by the Shona people. Hence the biggest felt need of many Shona people is, relief from the effects of witchcraft and only the traditional healers are the experts to do that¹⁷³. Ramashapa (1996:358) points out that the movement of church members from the churches that do not clearly practice faith healing to those who practice it, is a sign of the fear of witches and other destructive powers. Manala (2004:1494) purports that in the minds of many African people there is no doubt as to the reality of witchcraft. This is also supported by Mwalwa (1998:6) who adds, “I am convinced that witchcraft is not imaginary or unreal. It is a strong force in Africa. It is an existential reality. The fear of witches is very real.”

On the other hand, Shorter (1985:95) argues that witchcraft accusations enable the individual to exculpate themselves and to receive public acknowledgement that they are on the side of angels. Therefore, HIV infection is not due to their own mistakes, in competences or sin but it is the work of an enemy who is an enemy of the whole community. Hence blaming witches and evil spirits may seem to provide security, acceptance and shields the HIV patient from being stigmatized, labeled and discriminated. In this manner, responsibility can be shifted and this can lead to denial of taking responsibility as well as denial of the disease.

However, for a long time there has been an unquestionable acceptance of ‘expert knowledge’ of the medical doctor which has its roots in the colonial era. Official knowledge has a history of being considered as scientific and modern developed as it were in European centres of knowledge. Patients’ knowledge has little room in the scientifically tested and proven body of knowledge. With the dominant logic of globalization, which tends to import goods and services baked in the Western liberal world the way HIV and AIDS was presented and the solution offered were problematized especially when what is recommended as a solution goes contrary to

¹⁷³ Nyirongo (1997:183) and Kgatla (2000:151) agree that in the African society fear of witches is evidenced by the number of visits the people make to the traditional healers to obtain omelets and protective charms

the worldview and identity of the people. It is therefore important that, there should be co-ordinate efforts from both the local and the global community. The limits imposed by globalization with respect to the cultural context of the African communities make it imperative for the primary health care delivery system in Africa and Zimbabwe, in particular, to supplement the help that comes from globalization with a spiritual and pastoral approach to healing which takes the African realities into perspective.

4.2.1.3 Sin and punishment

Mother

What have I done to deserve this? What sin have I committed to have me and my children HIV positive? I have known one husband in my life but my faithfulness has not helped me at all. My husband is the one who was unfaithful. But it was me who tested first and he told me it was my disease. He didn't want anything to do with me. He even abandoned the bedroom from the day I tested positive until the day he became seriously ill. I had to take care of him until he died. Why is my life so difficult?

Mukoma T.J

I am dismayed. Why am I being punished like this? What is the purpose of my suffering? Haven't I paid enough? Will this ever end? I have no children. I have never had any children and it seems I will never have children because of this disease. Why me?

Bongmba (2007:4) affirms that, the view that HIV and AIDS is a punishment from God for this present generation for its promiscuity is not strange in an African context, where apart from Christianity, cosmology also teaches that God or the ancestors often punish people who have failed to live up to their obligations. Given the African concept of sin, HIV and AIDS is clearly a sign that the harmony between the ancestors and man has been broken. The Christians believe that sin alienates one from God as it is perceived from the Bible. Maimela (1985:65) points out that sin is seen as something God punishes us for, instead of something that God rescues us from. Louw (1998:404) states that, sin is perceived as a relational problem hence guilt as an acknowledgement of transgression is an ethical problem. The Biblical view is that, the fundamental wrongs in people's behavior cannot be cured effectively until people are 'saved' by

a radical inner transformation of healing and it is freely given as God's gift through Christ, thereby enabling them to live as they should. As such, to the believer, guilty is an alarm system warning him/her that something is wrong in the moral sphere of self responsibility.

The Christian conscience creates sensitivity which helps to be in contact with the reality of responsibility. The conscience can be cleansed and purified through forgiveness offered in Jesus Christ (Heb, 9:14, and 10:22). The Christian through the Scriptures understand that forgiveness is the cornerstone of Christianity; hence forgiveness is the Gospel of God's grace and unconditional love. Confession of one's sins and the discovery of reality of one's guilty can take place when one realizes who God is. The believer understands that, when one is forgiven, then one is reconciled to God and its part of healing and it is freely given as God's gift through Christ even to those infected or affected by HIV and AIDS.

To the Shona, sin is better expressed as 'wrong doing' and the concept of sin is therefore conditional and does not exist in an absolute sense but always within the community and creation¹⁷⁴. Magesa (1997:161) adds that, sin depends on the context and community and if humans mistreat one another it displeases God and when they reconcile, they are by the same token reconciled with God. The most striking aspect of African society is the willingness to forgive and not to avenge and there is no emphasis on punishment but on making friends¹⁷⁵.

Louw (2008:427) argues that, the central theological problem in the HIV debate is the notion of God images and because of the suffering experienced by people living with HIV and AIDS, they are often inclined to revert to negative images of God which are sometimes provoked by the teachings of the church. These negative images of God include the following, a vindictive judge, a rigid bookkeeper of all our sins, a sadistic brute who takes pleasure in our suffering and an indifferent God who does not care about humanity's suffering. Hence the issue of who is God to the participants became imperative. Chalk (2006:213) asserts that in the Christian faith, God is also viewed as a judge and there will be a final judgment of all humanity at the end of time. Bongmba (2007:77) argues that, viewing God as a judge contributed to theologians and the church to respond to the HIV discourse from a moralistic approach as well as from the cause and

¹⁷⁴Thorpe (1991:114)

¹⁷⁵Zulu (1998:161)

effect paradigm which meant HIV was assessed as a punishment by God. This has given rise to discrimination, isolation and stigmatization of people living with HIV and AIDS. Scripture and Biblical sciences ought to be interpreted with cultural categories and project the epidemic of HIV and AIDS as a sickness and not as a divine punishment thereby eliminating power structures and condemning pseudo attitudes that could lead to stigmatization and exclusion against the victims of AIDS. The challenge is how do we bring back that which is lost in the church and society?

4.2.1.4 The chain reaction: Broken relationships and HIV infection

Together with the co-researchers we observed that concerning the spiritual root causes of HIV and AIDS, there are affected parts, which are inextricably intertwined with action in the spiritual realm. The person does something wrong, which angers the ancestors who are the custodians or protective forces around the person and when they are angered they remove the protection and any evil or bad omen may befall the person. That is why, when they are not sure of the wrong they have committed they ask the question why me? The questions asked by the participants, are in line with the fact that for the Shona, there is no such thing as an event without purpose. The fact is that everything is unified, interdependent and an integrated whole; there is no separation between the physical and the spiritual. Although the Shona people may acknowledge that HIV is a virus that causes AIDS, which can manifest physically, they go deep to state that, what caused the person to be infected is spiritual and that is the primary cause of the disease.

The participants made it clear that God is not necessarily seen as the direct origin of HIV and AIDS or of all suffering and sin but He is somehow linked to it. When there is a broken relationship between the spiritual realm and the person that creates a gap, which allows the virus to enter the body of the person. Hence, whatever is not right spiritually manifests physically as a disease and in this case as HIV and AIDS. Therefore, for healing to take place the spiritual healers have to be consulted. The participants made it clear that their first call for help was to consult the traditional healers or the prophets as the spiritual healers. According to the participants' perspective, what comes first is not the HIV infecting the body but the broken relationships, which creates a gap between the individual, other fellow humans, the living dead and ultimately God and that allows the virus to infect the person. Some of the participants have this to say to consolidate this fact;

Mother:

My relationship with my husband was not good at all. Our marriage was problematic. He was always unfaithful to our marriage relationship. He had many girlfriends. His family knew about his problem but what could they do? To put it straight we were not happily married but what could I do? I had nowhere to go with all the children. He was the breadwinner and I was just a housewife. The broken relationships create a way for the virus to enter the body because if God has removed His protection from you anything can happen. In this case you can be infected by the HIV. So the primary cause of the disease is not the virus entering the body of the person but the broken relationships which is spiritual.

Mukoma Tippy:

For me what started this entire story were the problems in my marriage. Before the HIV came into our marriage we had problems and we nearly divorced. I moved away because of work and I started going out with other women. I committed adultery. God was not happy with me. He allowed the HIV to infect me. The thing is, HIV infection is not the root cause of the disease but the broken relationships which work like a chain reaction. To state it simply, I wasn't happily married. I was trying my best to be a good husband but my wife was always unhappy with me. I got to the point where I just didn't want to be with her. So when the opportunity came to be transferred. I took it up. But here I am now. I am HIV positive and the problem started with in our marriage.

Mukoma K.K

In our culture nothing just happens. My wife was not just taken by another man. A demonic force was working because my ancestors were not protecting me because of something wrong which I had done. The relationship between me and my ancestors was not healed and when your ancestors are not happy with you, God is not happy either and His protection is removed from you that's when such diseases can come on you. The primary cause of HIV and AIDS is these broken relationships. Whether between the person and the living or the living dead everything is interconnected.

What seemed to emerge here was, the broken relationships cause a chain reaction in the spiritual realm, which may start with the living and then to the living dead and to God, creating a gateway for the HIV to infect the person as God's protection is removed. According to the Shona, healing therefore includes, restoration of broken relationships, which include inner healing and rebuilding of broken relationships. The process of healing is integral and includes holistically, God, the spiritual world, the ancestors and it involves the patient, complete family and community. The human person plays a central role in all African thinking but always in the context of the community hence the *ubuntu* concept, which means a person is only a person through other people. Bujo and Ilunga (2003:126) state,

Among the Bantu the individual is necessarily communal. One is human in relation to the community. Separation from others makes him lose humanity. A human becomes human as far as he shares in the life of the community in solidarity with the fellow creatures. Becoming a person in Africa is interpreted as acting more or less effectively but as the individual directing himself towards the community

Although the natural causes of HIV and AIDS may be acknowledged by the Shona people, the traditional healer gives the spiritual causes of the disease and the treatment plan¹⁷⁶. The African healing system is culturally determined and is meaningful only if understood from a social-cultural point of view. Technology and modernization may have influenced the lives of Africans in one way or the other but the practices of African indigenous healing, still employ traditional ways of healing different illnesses. This is the reason why the participants' first call for help was to consult the traditional healers. But they did not stop there. Some went to the faith healers before they finally went to the hospital. Seeking help in these three different places is an indication that the participants based their understanding of illness and healing on the three worldviews, which are socially constructed. Hence the next section deals with the social constructions of illness and healing among the Shona people which emerged in this research journey.

¹⁷⁶Ncube (2003:98)

4.3 The social construction of illness and healing among the Shona people

The Shona people utilize three main social constructions of illness, health and healing namely the traditional approach based on the Shona belief system, the biomedical approach that is located within the Western scientific medical paradigm and the Christian approach based on Christian Spirituality. The Shona traditional/cultural healing system seeks to cure and heal illnesses by restoring harmony, balance and equilibrium not only by alienating physical symptoms but also by re-integrating the person with his or her community, the earth and the spiritual world. The Shona traditional belief system and their worldview have been under threat since the advent of colonialism and Christianity. A few bad things that were seen being practiced by the Shona in the name of culture, were enough to brand the whole indigenous culture anti-modern, ungodly and therefore retrogressive. Rodlach (2006:41) articulates, “Zimbabweans in the quest for healing from the impact of HIV and AIDS may use Christianity, traditional systems or both.” Chavhunduka (2001:4) has observed that “many Christians in Zimbabwe continue to participate in traditional religious rituals. They continue to consult traditional healers; many Christians believe in witchcraft, some even practice it or attempt to practice witchcraft.” The participants in the study stated that, their first call for help when they became sick was to the traditional healers. Hence, the next section discusses this issue.

4.3.1 Consulting with traditional healers in the Shona culture

According to Lwanda (2005:72) the training of traditional healers usually involves a number of steps, usually a calling, implied or in dreams, initiation into the practice and finally a period of training into traditions and malfunctions of the body, the use of medicines, divinations, herbalism or other fields of traditional medicines as appropriate. This experiential training is combined with a clinical approach that gives psychological and social explanations for diseases. Traditional healers are perceived as being able to offer a comprehensive range of diagnostic and therapeutic services.

Treatment, illness and disease in the Shona society is defined in terms of categories and different types of *n'angas* or traditional healers can be consulted¹⁷⁷. Firstly if the illness is not very serious, herbalists are consulted and they specialize in herbs that are sold to customers to treat a variety of illnesses or misfortunes. These are generally regarded as good, although they may cause harm by using poisonous herbs. The next category is that of bone-throwers/soothsayers/who literally use a variety of magical items such as pieces of rock, bones, wood, hair etc. to reveal the unknown. These are consulted on a variety of issues, such as determining the cause of a sudden illness or crisis or advice when an important decision has to be made. If the problem is witchcraft, the *n'anga* will use the bones to identify the witch or guilty party. If the problems are caused by an angered spirit, ancestors or avenging spirit, the spirit must be placated by prayer and sacrifice.

The most feared *n'angas* are those magicians who could use magic to protect or harm people. They could for instance be hired to strike a house with lightning or inflict pain or death on an enemy. They can also be hired to cast spells to protect someone who is under attack from a *mudzimu shavi* or magic spells of another person. Hence this understanding of the causes of serious illness like HIV and AIDS is instrumental in shaping the form of therapy. Therefore, for effective therapy, spiritual guidance is therefore a prerequisite that is why the patient sought the guidance of traditional healers.

However, like any other health delivery system, the traditional Shona system of health is susceptible to abuse and to unscrupulous practitioners. The Zimbabwe National Association of traditional healers (ZINATHA) has therefore been established to act as a watchdog and every traditional healer is obliged to register with ZINATHA. According to Terry (2006:83) ZINATHA was formed after independence and by 2006, 52 500 traditional healers were registered with ZINATHA compared to 2000 Western trained physicians in Zimbabwe. Terry adds that it is impolite to call them witchdoctors in professional circles, as they outnumber the

¹⁷⁷Bannerman (1983:21) traditional practitioners define life as the union of body, senses, mind and souls and describe positive health as the blending of physical, mental, social, moral and spiritual welfare. Materialistic issues are considered explored first when attempting to explain and treat an illness. However, if solutions cannot be reached recourse is taken to the metaphysical world. Hence both natural and supernatural modes of healing are used.

medical doctors. They are a force to be reckoned with in the HIV and AIDS discourse in Zimbabwe. Their other added advantage is that, they can be found everywhere and at anytime. Jackson (2005:252) is of the opinion that, because the traditional healers are trusted and are such strong repositories of tradition and culture they have enormous influence in the quest for healing within the HIV and AIDS pandemic.

However it would seem like HIV and AIDS has become scandalous even to the traditional healers, as the participants have indicated in the study. For most of them as is the custom, when they were sick, their first call for help was to the traditional healer. But no matter how many visits the participants made to the traditional healer no healing took place. They continued suffering and got some relief when they went to the hospital. Although they are now on ART, they still struggle with the issue of why me with this terrible disease, which the traditional healers cannot do anything about. I found this very intriguing and wanted to find out from the participants whether they are still visiting the traditional healers as before and being Christians, how did they feel about it. The answer was an emphatic yes. Here is what some of them said.

Mainini Shupi

I still go to consult with the traditional healers for other problems and I have been successfully helped. They are also human beings and they cannot know everything just like the medical doctors. Sometimes they give you wrong treatment and some people have died because of that but you can't stop going back when you have a problem. HIV and AIDS has become a very big issue to the traditional healers, the prophets and the medical doctors. No one has the answer except God.

Mukoma K.K

We still consult with the traditional healers whenever there is a problem. We can't throw them away because they have failed to deal with HIV and AIDS. No one has the answer to this disease except God. As for me I go to the traditional healer without fear of what the church will say because I know everyone does it even the pastors. It's only that they go there at night. But it's our ways I don't see any problem with that.

Mother

For me, God uses many people whom He has blessed with the healing gift to help the people. Whenever I have a problem, I can go to the traditional healer or to the priest or to the hospital. I don't see any problem there. These people work together because sometimes the traditional healers tell you to go to the hospital to be treated for a certain disease. And besides they are also human beings and they are limited. Only God is the ultimate healer.

Mai Chipso

I still seek help or healing from the traditional healers on other life problems. I don't blame them for not succeeding in terms of HIV and AIDS. No one else has. I don't feel guilt to go and consult with the traditional healers. It's my life and I make that choice.

4.3.2 Consulting with the faith healers or prophets

In Zimbabwe the faith healers or prophets are found mainly in the indigenous churches, which are commonly known as the Pentecostal churches, spirit churches or independent churches. These churches are a breakaway from the mainline churches, which are of the missionary origin. Hendriks (1999:90) is of the opinion that the decline of adherence in the mainline churches lies in their inability to adjust to the rapid changes taking place in society. In addition, Pentecostal churches address needs not met in mainline churches such as healing, deliverance and the spirit world¹⁷⁸. Worship, deliverance or healing services are livelier than in mainline churches and involves the use of drums, dancing, shouting and clapping hands. Hendriks (1999:68) is of the opinion that, those adhering to these independent churches are mainly from the lower income brackets. Healing is an essential element of the primary piety, the archaic spirituality that Pentecostal worship brings to the surface.¹⁷⁹ Ayegboyin (2004:79) also adds that, healing is central among the Pentecostals and the belief is that the one who is called to the healing ministry will also be equipped to perform signs and wonders foremost of which is to heal the sick and deliver the oppressed. The themes on healing, deliverance and protection are stressed at conferences, seminars and conventions. Ayegboyin (2004:79) adds,

¹⁷⁸Pretorius and Jafta (1997:222).

¹⁷⁹ Corr (1995:110)

The enthusiasm of the willingness of New Pentecostal Churches to address people's problems like sickness, poverty, attacks from evil spirits, barrenness, loneliness and all kinds of unproductiveness and misfortunes demonstrate the centrality of healing and wholeness to the African

Biri (2012:5) points out that the delivery sessions, services and crusades are noted for a strong undercurrent of the belief in witches and witchcraft activities. Satanism is often spoken of referring to witches and witchcraft. It is argued and taught that when one is born again, one has to make a complete break from the past (2Cor 2:17). A complete break is made by denouncing the past verbally (Romans 10) and attending deliverance sessions because the evil spirits that dominate families will continue to haunt the believer and prevent him or her from prospering in life.¹⁸⁰ The prophets or healers who are mainly known as the men or women of God use a variety of icons in healing and deliverance. For example, the prophet's portrait may be found in every church. The presence of the portrait claims and reinforces the fact that the prophet is the founder and president of the church and this has a strong autocratic and authoritarian undercurrent.¹⁸¹ Biri (2012:5) asserts that there is a belief that, the portrait has healing powers and several people claim to have used the portraits to cast out devils and to heal the sick.

One of the most famous prophets in Zimbabwe Makandiwa is believed to use his cream jacket to heal people and it has become a deified religious icon. Many members of his church have defended the use of his jacket¹⁸². Makandiwa is reported to allow some of his congregants to visit TB Joshua the Nigerian Pentecostal healer or miracle worker for healing and he usually uses holy water. In like manner, Pentecostals like Benny Hinn have been praying for cloths for healing but for specific illnesses. Some Pentecostals in Zimbabwe use cloths for healing as well. The same cloths may be used for protection and one can wipe a car for example and in future through faith, will acquire one like that.

However, the critics of Pentecostalism in Zimbabwe state that Pentecostal Churches oppose traditional medicines and the use of icons by traditional healers because it is tantamount to worshipping the ancestors instead of God. The use of and quest for healing icons, betrays the

¹⁸⁰ Biri (2012:5)

¹⁸¹ Biri (2012:5)

¹⁸² Biri (2012:5)

Pentecostals in their affiliation and allegiance to the traditional conception and methods of healing. They appear to have been sourced from the traditional religion but the methods have been re-defined and re-socialized in new forms. Protective icons resonate well with the traditional beliefs that continue to inform their perceptions and conception of healing and protection expressed through protective charms and emblems. They have found ways of accommodating old values in their delivery services, sessions and crusades. They have a religious inclination that seems to tap into the reservoir of the Shona traditional religion in search for the meaning of life. Zimbabwe Pentecostals has been a popular religion that is not alien to the people because it does not offer anything completely new. Biri (2012:10) argues that this has made Pentecostalism viable to many Zimbabweans because ATR continues to be an “echoing” voice hence many people flock there.

The participants in this study indicated that they went to consult with the faith healers or with prophets before they went to the hospital when they were sick but they could not be helped. I wanted to know from them whether they could still trust the prophets and if they had a problem whether they could still consult with them. And here is what some of them said.

Maininini Shupi

For some other problems I still go there to look for help and in some instances I have been helped. It is only HIV which has confused the prophets, but they are very effective with other problems especially when it comes to the casting out of demons and evil spirits they are good. I don't see any difference between the faith healers and the traditional healers, the source of their power is God. If God wants to use them at that time He will use them and if He decides not to use them, He will do that. But in our case, only God can help us.

Mother

I belong to one of those churches. The prophets there are very good with other problems although HIV and AIDS is very tricky for them as it is with the traditional healers and the medical doctors. They are very good with casting out demons and witchcraft things. But like everywhere else you can find the fake ones and the genuine ones too. The fake ones are terrible

and they lie a lot to people but because people are desperate they still go there to look for help. It's a pity.

Mukoma K.K

I am the unlucky one because I think I have been consulting with fake prophets wherever I went. They did not manage to resolve any of my problems. I really don't know who can help us in our predicament. No one has the answer not even the medical doctor. Life is very difficult.

4.3.3 The biomedical intervention

The discipline of public health seeks to improve the health of all people regardless of their nation or culture and subscribes to the biomedical model. The global nature of this discipline lends itself to establishing global guidelines parameters and goals. This can be good because it allows for the comparison of information about health across nations and gives a clearer idea about the human population as a whole. However, global guidelines can also be problematic because they generalize the diversity and complexity of human health and healthcare making their guidelines less meaningful, useful or effective in a socially specific situation. Health and illness is a central and cultural specific aspect of life in almost any society as explored in this research. However, it is important to recognize that biomedicine is a socially produced and understood medical system and it cannot be treated as a universal truth. There are known values and advantages of biomedicine as there are of any medical system. In addition, biomedical interventions cannot stand alone and be successful but must be introduced and constantly reassessed, in each socially specific setting.

Louw (2008:37) discusses the impact of a biomedical model on health care and all aspects of caring for the sick pointing out that, the advantages are accuracy in diagnosis and sophisticated methods of treatment and cure. Nevertheless, medical care has developed to the extent where the patient is no longer the central figure. The entire human being can be reduced to a physical, biological or chemical entity to be analyzed and as a result of the power of the physician; the modern scientific understanding of life has gained a pseudo-religious character¹⁸³. Louw

¹⁸³Louw (2008:38)

(2008:38) continues to argue that, a biomedical model holds the real danger that it can easily degrade human beings to the level of mere objects, by ignoring the spiritual and cultural dimensions of life. Louw (2008:41) charges that a human person should be regarded as a relational and social being, acting within a cultural context making the being of the person more important than the function of his/her body. In this research I concur with Louw's (2008:41) assertion that because of the tremendous influence of a Western biomedical model in the primary health care delivery system, it becomes imperative to address the issues of health and illness within an African context. In this regard, as the participants are receiving care within the PHC, I wanted to find out from them, what their perceptions were of the type of care they received from the hospital. Below are some comments made by some participants in this regard.

Mukoma Tippy

As I mentioned at the beginning, I had been sick for a very long time and nothing seemed to help until I came here at the hospital to be tested. I am sure all of us in this group we know what it is like to come here. It is a matter of life and death. It is always the last resort because the people here are not friendly at all. The medicine they give us is good and it works but they don't look at us as people. You can't ask them anything. They are so rough and when it's that time of the month when you have to come for your refills you drag coming here because you know that they can just shout at you for nothing. They can humiliate you and call you names. The ones they call counselors, they just ask you if you have any problem with the medication and if you say no they tell you to go home. They don't understand what it is like to live with this disease.

Mai Chipso

The reason why people delay to come to the hospital even for testing it's because of the treatment of the nurses at the hospital. They are so rough and they act as if they know everything. The medicine they give you works that is why we are still around and looking well. But it is the staff which is not good at all. The HIV counselors they don't ask you about your life. They just want to know whether you are experiencing any problems with the medication and if you say no then that is it. They don't talk to us about what is going on in our lives. They don't talk about the challenges we are facing by being HIV positive. It looks like the idea here is as

long as we are on medication we will be fine. But that is not like it. This disease is more than one can explain.

Mukoma K.K

No one wants to come to the hospital. If you are treated badly you cannot argue or ask questions for fear of being neglected or given wrong drugs which can kill you. But in the end you just come to the hospital because everything else has failed. The counselors do not know anything. I wish something to be done about our care here.

Mai Paida

I don't like coming to the hospitals. The nurses are not kind. They don't treat us as people. The thing is you can't complain because they seem to be the ones holding the key to your life. Ever since I tested positive, I have been coming to this hospital but I have never seen a counselor. No one has ever asked me about what it is like to live with HIV and AIDS. After every hospital visit I struggle with feelings of guilt and humiliation because of the treatment we get here. We are looked at as if we are the modern day lepers. But because we want to live, we have to continue coming. What else can we do?

4.3.4 The interplay: Shona traditional beliefs, Christian faith and the biomedical intervention

Healey and Sybertz (1996:292) add that most Africans tend to uphold two faiths. They maintain the Christian faith when life is good and gay but hold onto their traditional beliefs when the fundamentals of life are at stake as they are within the HIV and AIDS pandemic. Prior to the coming of the missionaries, there was no Shona word for religion. It was not some part of life one could step back from and analyze, for all of life was thoroughly spiritual. Christianity changed all that firstly by doing what Brand (2002:94) says,

Christianity casts traditional healers and diviners in the role of evil doers. Traditionally these religious specialists were held in high regard. Their lives were devoted to searching out causes of evil and illness in the communities suggesting ways of healing and

reconciliation. They were the doctors, therapists and consultants of the traditional society. With the coming of Christianity their position was seriously undermined

Another consequence of Western missionaries' view on healing namely that it was primarily diseases, which had to be cured had serious implications in the missionary encounter of the African people with Western medicine¹⁸⁴. For Africans, Shorter (1985:3) says "it is not illness that are healed but people". To put it differently, it is not the physical manifestation of the disease (which is but a symptom) that has to be healed, but the broken relationships among people, the environment and God (which is the real illness).

Hinga (1994:346) highlights that the hand in hand glove relationship between Christianity and the colonizers led to a certain restlessness among Africans, which led some to completely reject Christianity as they also attempted to resist imperialism that served to be its flipside. Hinga (1994:346) eloquently depicts that colonization and evangelization were two sides of the same coin of European presence in Africa and the 19th century. Christianity was the religion of the imperialists and this affected the way Africa viewed Christianity. The early missionaries tried to destroy Shona religion and their medicines regarding them as against Christian faith and morals and as unscientific and anti-Christ¹⁸⁵. They also preached that Shona religion promoted the belief in witchcraft and encouraged people to worship their ancestors instead of God. Hence they tried to stop converts from taking part in African traditional religious rituals and from consulting traditional healers who they described as heathens.

On the other hand as lamented by Saayman and Kriel (1992:46) medical missionaries claimed to heal in the name of God, yet in their practice failed to integrate their medical practice in a way which was compatible to the African culture. Medical missionaries claimed special expertise in the area of diagnosis of illness, yet failed to ground their diagnosis in an understanding of the sick person within his/her cultural presuppositions about causes of diseases. This caused a contradiction in the life of the Shona patient, who had to submit to the treatment with at least an outward appearance of accepting the assumptions underlying this treatment. And what did this do to the human dignity of the African people? In this regard, Togarasei (2005:61) noted that

¹⁸⁴ Saayman and Kriel (1992:45)

¹⁸⁵ Chaminuka (2001:56)

when the Shona Christians go to seek pastoral counseling often it is an issue of personal and religious confusion caused by the demonization of their traditional religion by the missionaries. Togarasei (2005:61) adds that with the demonization of their religion, the extended family has been broken up and in some cases rivalries have been created because Christians who no longer want to participate in traditional rituals are often accused of witchcraft by their traditional relatives.

This attempt to destroy Shona religion has not succeeded. Many Shona Christians have continued to participate in traditional religious rituals and they have also continued to consult traditional healers up to date as evidenced in this research. In fact it is their first call for help when they are sick. Traditional religion is involved in all aspects of the Shona people's life bringing together God and the spirits into every activity of their life. Traditional healing methods have succeeded in curing and healing a large number of illnesses in the past but however, they have not succeeded where HIV and AIDS is concerned as articulated by the participants in this research. HIV and AIDS appears to have become scandalous even to the traditional healers and the ancestors as well. It seems, no matter how many broken ties have been mended and how many rituals have been performed, people continue to suffer and die from AIDS, to include the innocent ones and the young.

On the other hand, it is ridiculous to acknowledge the number of churches in Africa, sub-Saharan Africa with many priests and pastors who engage in healing ministries but are unable most often to depict the spiritual root causes of HIV and AIDS. The priests and the pastors could be therefore classified as good nurses (taking care of the sick) and bad physicians (not diagnosing well what is actually the root cause of HIV and AIDS). Hence this quest for a spiritual and pastoral approach to healing which empowers the people living with HIV and AIDS to be the experts of their own lives becomes imperative within the HIV and AIDS discourse. Bujo (1992:65-66) asserts, "it is irresponsible to celebrate the Eucharist with drums and dancing while leaving the people to their fate." Christians have to develop a pastoral theology that measures up based on a deep appreciation of the value of human life and a holistic understanding of the human person.

The participants in the study being Shona Christians who are receiving care from the medical hospital presented to me the three worldviews of which, at times I struggled to understand which worldview were they using at given times. I observed that the participants will vacillate from the Shona traditions to Christianity and then to the scientific biomedicine worldviews without difficulty. I became curious and wanted to understand how they did that. In this regard, I will discuss how the Shona seem to be managing the three worldviews in terms of interpreting their experiences of being HIV positive and their quest for healing.

4.3.5 The quest for healing: The instinctive eclecticism

The three worldviews are viewed differently but are regarded as complementary rather than mutually exclusive. The Western trained doctor, traditional healer and the faith healer have the same goal which is to help the sick, cure illness and relieve pain and suffering and comfort patients and their relatives¹⁸⁶. Hence there is no need for conflict and the patients in this study seemed to realize that. Furthermore, Viriri and Mungwini (2009:188) add that, it has been observed how the Shona have developed coping mechanisms to survive with the environment characterized by competing worldviews without neglecting anyone of them. The patient visits the three systems whenever they feel the need to in search for healing. Historically, many schools and hospitals in rural Africa were run by church related organizations which led to cross fertilization between the African ethos and Christianity resulting in the emergence of the so called African Indigenous Churches¹⁸⁷. Thabele (2008:241) points out that some Africans have adopted the Christian faith but without forsaking their belief in the Supreme God, ancestors and the power of witchcraft as we have already noted in this study.

It appears as if the Shona have developed this instinctive eclecticism as a way of coping with the different but competing models of understanding the world and explaining events in life. The Shona have tried to harmonize the three worldviews in their existential circumstances especially when someone is sick as observed in this research. The mission of those who go to the traditional healer and the faith healer was to ascertain the spiritual cause of the illness and the mission of those who go to the medical doctor is to ascertain the natural cause of the illness. The three

¹⁸⁶ Gumedde (1990:153)

¹⁸⁷ Lubbe (2004)

different and often taken as antagonistic worldviews are seen as kind of complementing each other. Put together the three worldviews constitute an eclectic patchwork, a hybrid that the Shona have come up with, to negotiate their way and deal with the existential realities facing them in contemporary Zimbabwe. It is interesting to note that after more than a century of conceited efforts to obliterate Shona culture, it has remained resilient and people still consult the traditional healers as indicated in this study. Horton (1998:184) states that we cannot ignore the way the Shona look at social relations and disease and misfortune so frequently postulated by traditional religious thought. Horton (1998:84) adds

Let us remind ourselves at this point that modern medicine though long blinded to such things by the fantastic success of the germ theory of disease are once more beginning to toy with the idea that disturbances in a person's social life can in fact contribute to a whole series of sickness ranging from those commonly thought of as bodily

Viriri and Mungwini (2009:183) add that this is exactly what African metaphysics has always held about disease and the traditional healer's efforts to cope with the situation by ferreting out and attempting to remedy stress producing disturbances in the patient's social field are probably very relevant. African people have strong memories of their local practices and this self conscious knowledge motivates them as they rely heavily upon these concepts. They have mastered skills to adapt and transform local practices in order to suit that changing cultural and socio-economic needs of their immediate surroundings. Mbiti (1975:17) supports that religion is part and parcel of the African heritage, which goes back many thousands of years and Africans are generally religious and the key note of their lives is religion. In all things they are religious as supported by Leonard (1966:429) who observed that;

Africans are in the strict and natural sense of the word truly and deeply a religious people of whom it can be said that they eat religiously, drink religiously, battle religiously, dress religiously and sin religiously.

In addition, Viriri and Mungwini (2009:185) postulate that for the Africans their religion is their existence and their existence is their religion. Consequently, it is difficult to separate the life and

living of an African from his religion. In all things they are religious. Their religion forms the foundation and the all governing principle of life to which Mbiti (1969:2) adds,

Because traditional religion permeates all the departments of life, there is no distinction between the sacred and the secular, between religious and non religious, between spiritual and the material area of life wherever the African is, there is his religion. He carries it to the field where he is sowing seeds or harvesting a new crop, takes it with him to the beer party or to attend a funeral ceremony.

I think this is something the Christian church can learn from the Shona traditional religion. Maybe if Christianity can be an everyday experience which is mingled with every day activities it could become more effective. The Western trained doctor, the traditional healer and the faith healer have the same goal, which is to help the sick, cure illness, relieve pain and suffering and comfort the patients and their relatives¹⁸⁸. Hence there is no need of conflict. However, in terms of holistic healing of people living with HIV and AIDS the Shona traditions, the church and the scientific modern medicine, the three put together have failed in this regard as articulated by the participants in this study. The scientific modern medicine has failed to cure AIDS. The church and the traditional religion have failed to address the spiritual issues raised by people living with HIV and AIDS and their suffering continues with unimaginable, indescribable pain. Now HIV and AIDS has gone beyond the expertise of the traditional healers, the church pastors and prophets where do they turn to for healing since there is no cure for AIDS? Hence this study quested for a spiritual and pastoral approach to healing within the primary health care delivery system in Zimbabwe. In this regard, life remains a heavy load for the Shona people living with HIV and AIDS. I wanted to know from the participants who then was the question” why me?” and all the questionings directed to since the traditional healers and the church have failed to supply them with the answers to their questing. The next section deals with what the participants named as the problem (1.12.1.3.11.1) that is ‘spiritual pain’ which they experience as they struggle to find spiritual healing.

¹⁸⁸Gumede (1990:153)

4.4 Spiritual Pain

As part of naming the problem, deconstructing the problem and to deepen the participants' understanding of the problem, I wanted to find out from the participants what the question 'why me' and all the other questionings meant to them and who were they directed to? As such, the participants named the problem as spiritual pain which they understood as follows.

4.4.1 Mai Paida and the inner pain

Mai Paida: I want to know why me? Why am I the one infected with HIV and not others?

Farirai: Who are the questions directed to?

Mai Paida: To God

Farirai: Who is God to you?

Mai Paida: God is Mwari. He is Musiki or the creator, the giver of life. God is in control of everything including our lives. He has power to do anything. He has power to protect people from diseases. He is a powerful God and what I want to know from Him is why me? Why did he remove His protection from me?

Farirai: Is he going to give you the answer?

Mai Paida: I don't know and this is the struggle inside of me. I have been asking the same questions since the day I tested positive. I have tried to get the answers from the traditional healers. It didn't help. I have tried the prophets and it didn't work. And the pain continues deep inside of me. So God knows why I am suffering like this. He is powerful and I want to know why did He remove His protection from me?

Farirai: Why would He do that?

Mai Paida: Maybe I had sinned against Him.

Farirai: How do you connect this all powerful God to the possibility of you sinning and Him removing His protection from you?

Mai Paida: When one has sinned God leaves you alone and without His protection, anything bad can happen to you.

Farirai: So do you think you might have sinned for you to be infected by HIV?

Mai Paida: I think God is angry with me because I haven't been to church for many years. I used to pray a lot and we had a good relationship. But now things are different.

Farirai: How do you mean?

Mai Paida: I just feel I don't have a relationship with God anymore. I feel like he has deserted me. He has left me to suffer alone. I feel alienated from God and my life is empty.

Farirai: So is it a question of your relationship with God?

Mai Paida: Yes. I no longer have that connection with Him anymore.

Farirai: And you think because of that He would allow you to be infected HIV?

Mai Paida: Yes He let it happen. He removes His protection and anything bad can happen to you. But if you have a relationship with God He will keep you and no evil will come your way. For someone to get such a disease which no one can do anything about it is a very heavy punishment. This disease is very complicated because the *n'angas* failed, the church failed and the medical doctors can only do their part of which they can only do half of it since there is no cure for the disease. So only God knows why I am in this predicament.

Farirai: In other words you think you are in this predicament because God is punishing you for not going to church and not having a relationship with him?

Mai Paida: Yes

Farirai: If God can punish people as you are saying can you describe to me how you are experiencing this God personally?

Mai Paida: God can be anything it depends on what you are going through at that moment. In my case He is like a judge. With His power he can pass onto you any sentence and who can challenge Him?

Farirai: Are you saying God can be described according to the way you experience Him as you go through certain life experiences?

Mai Paida: Yes. There are times when you can experience God as a Father who is love and this is when things are going on well and when the situation changes you can experience Him differently maybe as a judge. Whichever the case maybe, God has the answer to my suffering.

4.4.2 Mai Chipo and the spiritual pain

Mai Chipo: I want to know why I have been cursed with this disease.

Farirai: Who is the question directed to?

Mai Chipo: To God?

Farirai: Who is God to you?

Mai Chipo: God the creator. *Musikavanhu*, the one who brought us into this world. The one who created the whole world. He is the source of our lives.

Farirai: So this God the creator who brought you into this world knows why you have been cursed with this disease?

Mai Chipo: Yes He is all knowing. He is Infinite Intelligence.

Farirai: And in this situation He knows why you have been cursed to become HIV positive?

Mai Chipo: Yes he does and he knows who cursed me. It just didn't happen

Farirai: You told me earlier that you have been asking this question since the day you tested positive and now its five years have you got any answers yet?

Mai Chipo: Not yet. God is not the one who cursed me but he allowed someone to do it?

Farirai: How does that happen?

Mai Chipo: There are witches who can curse you if they are jealous of your life and when the curse is upon you, you can have problems in your marriage and your husband may start cheating

on you like what happened in my case. I once had a beautiful marriage and some people became jealous of me and look what they have done to me?

Farirai: What is this curse?

Mai Chipo: It's like a bad spell *munyama* or *mamhepo* bad spirits which witches send to you and everything goes wrong for you.

Farirai: You are saying, the witches are the ones who sent you a bad spell then your husband started cheating on you.

Mai Chipo: That is what happened. He then started cheating on me and now we both have HIV.

Farirai: How do we connect this to God the creator?

Mai Chipo: I told you God is all knowing. He knows these people and He allowed them to curse me. He could have stopped them. He is all powerful.

Farirai: Why do you think God allowed these people to curse you?

Mai Chipo: It has to do with my ancestors as well.

Farirai: How are they involved?

Mai Chipo: Because they are the ones to protect me but they let the witches do this thing on me

Farirai: Why did they do that?

Mai Chipo: Maybe because ever since my father died I have never been home. I never went for his funeral. I just stayed away because ever since I got married I never went back home until my father was sick and he died. My father always looked at me as a difficult child who never listened. I ran away from home when I was in form three and got married to my husband. I told him not to go and pay *lobola* to my father. I told him a lot of bad things about my father. Then he became sick a few years ago and he died. My relationship with my father was bad and I think my ancestors are not happy with the way I treated my father. Now they could not protect me from these evil people who caused problems in my marriage. Because of that now I have HIV.

Farirai: In other words you are saying the relationship with your late father has caused your ancestors and God not to protect your marriage and this allowed the witches to cast a spell on you and now you are HIV positive. Is that correct?

Mai Chipso: That is very correct. So my father was not happy with me, my ancestors are not happy with me and God is not happy with me. I am not happy with myself for what I did to my father. I am not happy with my husband for giving me HIV. I have so many broken relationships. What do I do? I think God is the answer to all my problems.

In the case of Mai Chipso, her relationship with the father is very important as her father is the representative of all her ancestors. Viriri and Mungwini (2007:180) asserts that the Shona have a hierarchy of existence with God at the top, followed by the ancestors in their perking order of seniority and down to the living beings in which, one's father plays a significant role of representing the ancestors to the living. Therefore, much respect is accorded to him.

4.4.3 A letter to and from Mainini Shupi: A troubled spirit

Dear Mainini Shupi

I hope I find you well. I want to thank you for your willingness to be part of the group and for sharing your story with the others. I have a few questions I want to ask you as follow up to some of the issues you shared from your story with the group. I would be delighted if you would respond to them. You mentioned that you were very sick before testing for HIV and you went to see traditional healers but it didn't help. For two years you had diarrhea and you also went to churches but it didn't help and the prophets gave up on you and told you to go to the four ends of the earth. I want to know why you went to the traditional healers first and then to churches? Why couldn't the traditional healers and the prophet help you? Now that you came to the hospital and you got help is now everything alright with you?

I hope to hear from you soon

Farirai

Below is the response I got from Mainini Shupi.

Dear Farirai

Thank you for the letter. Thank you so much for the group you have started for us where we can meet and share our stories without any fear of being judged. I am delighted to answer the questions you raised. When I became sick I went to the traditional healers because I was convinced I was bewitched. And for the same reason when the traditional healers failed to help me I went to church to see the prophets. But I can't really say the traditional healers failed to help me. It's that what they said didn't work for me and their herbs did not help me at all. The prophets confirmed my suspicions that I was bewitched and they even told me the suspect who is my mother in law. I didn't dispute that. I also wanted to know why she did that to me. They told me repeatedly that she bewitched me because she didn't want her son to marry me. They also told me that it was easy for her to do what she wanted to do because my ancestors had their backs on me. I asked them why my ancestors had their backs on me and they told me that they were angry with me. I knew the reason why my ancestors were angry with me. It was because whenever they had a family traditional thing at home I never attended and I never participated in those things because I am staying here in town and these things have to be done in the rural areas. I have never gone back home since I came to work here in town about seven years ago. The other thing is since I came to town I joined these Pentecostal churches and I am born again. I felt I didn't need to do these cultural things because at church they teach us that the blood of Jesus can protect us. Now I am so confused and angry with myself, my husband, my ancestors and even with God. I sometimes doubt whether God is there. It hurts me so much and my spirit is troubled. I was doing everything they said we should do at church but still nothing protected me from getting HIV. I ask myself every day where is God in all this? Why did He allow this to happen to me? The problem here is that my Shona traditions failed to help me, the church has failed to help me and the hospital has done half the job. The medication cannot heal the spiritual pain within me. Only God can. He knows why I am suffering like this.

I hope I have answered your questions and yet I also have a lot of un answered questions.

Mainini Shupi

4.4.4 Mukoma Tippy and the struggle inside

Farirai: *In sharing your story with us you mentioned that you go to church and that's where the biggest struggle is inside you. I am interested to know what you mean by that.*

Mukoma Tippy: *As I said earlier I am a deacon at church. The whole church looks at me like I am perfect. But inside me I will be saying if only they knew my problem.*

Farirai: *And what is the problem that the church people must know about you?*

Mukoma Tippy: *I really struggle with guilt feelings in church. Sometimes I try to refuse the position in church but they encourage me saying I am very good at what I do. And I don't want them to know that I am HIV positive so I just do it. Then after church I will be saying those holy people how can they be served the Lord's Supper by a sinner like me?*

Farirai: *I hear you saying, you struggle with guilt feelings and you call yourself a sinner. May I know what the guilt feelings are about and why are you calling yourself a sinner?*

Mukoma Tippy: *Ok. I feel guilt for contracting HIV. I have been praying to God about what I did and I know God has forgiven me but I always feel maybe I am not clean before God.*

Farirai: *Who is God to you Mukoma Tippy?*

Mukoma Tippy: *God is Mwari or let me say He is Musikavanhu the creator of us human beings and the giver of life. I sinned against him and because of my sin God could not protect me from getting infected. Now no matter how many times I pray I just feel unclean before God and before my wife and the whole church. I just feel like life has lost meaning for me. My spirit is troubled.*

Farirai: *Where do you now stand?*

Mukoma Tippy: *I am nowhere? Noone else can help me. Only God can help*

Farirai: *How is God going to do that?*

Mukoma Tippy: *I don't know but since everyone else has failed only God is my hope.*

4.4.5 Spiritual pain and the human spirit

In deconstructing the problem, the co-researchers used metaphors to describe the spiritual pain such as, the inner pain, the inner struggle and I became curious to find out from them what they meant by that. Here is what some of them said.

Mukoma K.K: *It is the pain which is not physical. It affects your spirit (pamweya). No one can see it. Without the spirit there is no human person. The pain I am talking about is spiritual and it is in my spirit.*

Mukoma T.J. *I actually feel the pain in my spirit (mumweya). And this pain is different from the physical pain because it affects the essence of being human.*

Mother: *The human person has a spirit and this pain we are talking about affects the spirit (mweya). This is the part of the person which comes from God and when a person dies it leaves the body.*

Mai Chipu: *This pain affects the spirit. At church they refer to it as the inner person and in Shona we call it the spirit (mweya). The spirit is the essence of life.*

Mainina Shupi: *The pain affects the spirit and the human spirit cannot be seen. Therefore, you feel the pain inside of you. It is that part of being human that does not die. It leaves the body and goes to God or wanders around. That's why we have ancestors and we call them the living dead.*

Mai Paida: *For me, the pain is in my spirit. That's where the suffering is. And the human spirit is the real person because without the spirit the person cannot live.*

Mukoma Tippy: *The inner struggle happens in my spirit and no one can see it except when you find someone to share the pain with like in this group. The spirit is the part which leaves the body when you die. Without the spirit the person is dead although the spirit will continue to live.*

All the participants pointed out that the spiritual pain, which they referred to as the inner pain or inner struggle affected the spirit (*mweya*). The participants were in agreement that the human being has a spirit, which is not seen because it is inside the human body. As they spoke about the human person having a spirit, some of them touched their chests to illustrate that the pain was inside there. What the participants said about the human spirit, is affirmed by Viriri and Mungwini (2009:182) who state that, the Shona talk of their spirit being troubled, their spirit

being low or having lost their spirit or having their spirit revived and this is similar to the vital force. The Shona believe that, it is only by fortifying their spirits *mweya* through the use of magical recipes and through praying to the ancestors and pouring libation that they acquire resistance to malevolent external forces. Failure to do so would be to expose oneself to danger by giving up on the security that is guaranteed by the ancestors. Every person has a personal spirit. According to the participants, every person has a spirit, which does not die and this is the human part where the spiritual pain is experienced in this context.

The Shona understanding of the human person having a personal spirit agrees with the Biblical account of the creation of people. In the Shona Bible, Genesis 2:7 states, *Jehovha Mwari akavumba munhu neguruva revhu akafuridzira mweya woupenyu mumhuno dzake. Munhu akava mweya mupenyu*. The verse indicates that the person became a living spirit. However, when it comes to the English Bible the *mweya* (spirit) is replaced by soul and this raises a lot of confusion to the Shona because there is no Shona word for soul. It would appear as if the English Bible uses the word soul to refer to the entire human person. Here are some Biblical examples. Genesis 2:7 (KJV) states,

And the Lord God formed man of the dust of the ground and breathed into his nostrils the breath of life and man became a living soul.

Biblically soul in Hebrew (*nephesh*) and in Greek (*psyche*) in its broadest sense refers to the entire human person. We see this clearly in such texts as Genesis 46:26. *All the souls that came with Jacob into Egypt which came out of his loins besides Jacob's sons and wives all the souls were three score and six*. The souls here refer to the people that accompanied Jacob to Egypt Joshua 19:28 (KJV) *And that day Joshua took Makkedah and smote it with the edge of the sword and the king thereof he utterly destroyed them and all the souls*. All souls again refer to the people that Joshua and his troops killed. These Biblical examples clearly indicate that soul does not refer to the immaterial facet of human beings as the Shona and the Shona Bible refer to as the spirit, but rather to the whole person.

In an attempt to further deconstruct and understand spiritual pain of the co-researchers, I wanted to know how the spiritual pain being an inner struggle affecting the spirit of the person, can

manifest to provide a diagnoses and a clue for healing. The aim here was to also help them deepen their own understanding of the spiritual pain. Hence, I wanted to know from the participants how the spiritual pain operates in their lives? How does it show up since it is invisible? How does it work? The following section deals with the symptoms of spiritual pain described by the participants as how it manifests in their lives.

4.4.6 Manifestations of spiritual pain

To further deconstruct spiritual pain I asked the participants, how does spiritual pain show up? How does it operate? I now wanted to know from the co-researchers how they experienced the spiritual pain. I wanted to know from them how the spiritual pain manifested in their lives as a problem. I wanted to explore the effects of the symptoms of spiritual pain which was identified as the problem on their lives. I was also interested in understanding how the effects of the symptoms/problem suit or did not suit the person's life. I then went further to elicit a justification as to why they evaluated the effects of the problem in a certain way and I asked the question why? Hence the participants expressed that the spiritual pain (which is the problem) may be recognized by the following.

4.4.6.1 Anger as a symptom of spiritual pain

Mai Chipso: Spiritual pain is a deep pain inside of me and its real.

Farirai: Can you try and describe that deep pain?

Mai Chipso: For me it's the acute anger I feel. I am angry all the time.

Farirai: So the spiritual pain manifests as anger?

Mai Chipso: Yes and all I know now is to be angry. I am angry all the time..

Farirai: And what effect does the anger have on your life?

Mai Chipso: I am always angry with my husband who gave me HIV and at other people but I think mostly it is directed to God because I don't understand God's will in all this suffering. All my relationships are broken because I am angry with everyone. Anger is destroying me and all my relationships.

Farirai: How does this suit you?

Mai Chipo: Being angry all the time doesn't suit me at all. I will be trying to get rid of the pain inside of me and all I can be is to be angry.

Farirai: Why?

Mai Chipo: Because that is not who I am. I used to be a loving person and people used to enjoy being around me. This started when I tested HIV positive and it has been building up over the years. The frustrations of not getting any answers to my questions worsen the situation.

4.4.6.2 Doubt and meaninglessness as symptoms of spiritual pain

Mai Paida: For me the struggle within comes out as doubt and meaninglessness. Is there really a God? Is there really a purpose for existence? I struggle a lot with these two problems in my life. My life has been absorbed by these problems. My relationship with God has been affected a lot by doubt and meaninglessness. This doesn't work for me at all because I used to believe so much in God and I have testimonies of how God has been directly involved in my life. But things have become meaningless since I tested HIV positive.

Farirai: Why is it like that?

Mai Paida: Because the church teaches us that HIV and AIDS is a punishment for those who fornicate. I have HIV but I never fornicated so it's very confusing and one ends up doubting the existence of God and his love for me,

Farirai: How is this working out for you?

Mai Paida: This is not working for me because I know that God loves me and He cares for me because I could have been dead by now. The biggest problem is with the church when they label us as sinners and they start talking about God as a judge. I find myself nowhere. That's when doubt comes in and I don't find meaning in my life.

4.4.6.3 Isolation and abandonment as symptoms of spiritual pain

Mother: For me I feel all alone in my pain. I feel isolated from my friends, neighbors, and I feel like God has abandoned me. I have become very tearful. I am always crying. Sometimes my children ask me “mummy why are you always crying?” I am always weeping. Loneliness and deep deep sorrow is always with me. Sometimes even when I am with the others I just feel alone. When I am alone all I do is to cry a lot. I feel so sorry for myself for contracting HIV and AIDS.

Farirai: How does this work for you?

Mother: This doesn’t work for me at all. I eat and drink tears every day. This is not working for me at all

Farirai: Why?

Mother: Because I know I am a strong woman. I just need to reconnect with my God and it will be fine even though the world can judge me but God will not. I used to be a very happy person even though we had our marriage problems with my husband. But my courage used to help me a lot. But since HIV came into my life I lost it all. I ask myself all these questions which have no answer and I just cry. I just feel abandoned by God and very isolated from other people wherever I am.

4.4.6.4 Hopelessness and meaninglessness as symptoms of spiritual pain

Mukoma K.K: My life has fallen apart and it seems utterly meaningless devoid of all hope. Bitterness has consumed my life. I always ask, “What have I done to deserve this?” Since I tested positive my life has become meaningless and hopeless. I ask myself whether there is a reason for me to continue living or not. So I am always bitter and I don’t see anything good at all. My life is a mess. My first wife was taken by another man and now I marry another one whose husband used to sleep around and now she is probably the one who gave me this disease.

Farirai: How has meaninglessness and hopelessness affected your life?

Patient: My personal life as it is has no reason to live and I have become very withdrawn and people complain that I have become a bitter person. This doesn't suit me at all because I don't even understand myself anymore. I have lost my friends and my relatives also.

Farirai: How do you mean?

Patient: I used to be a very sociable person and I used to encourage others who were in difficulties giving them hope. At church I was very active but now it's different. I have stopped going to church. I can't even tell my own children the secret I am keeping from them. What life is that?

4.4.6.5 Confusion about God's love as a symptom of spiritual pain

Mainini Shupi: We all assume HIV and AIDS happens to someone else not us, and this has challenged my beliefs about life, myself and the future. I am confused. Sometimes I feel like I am going to lose my mind. I am confused about whether God still loves me and whether He cares for me at all.

Farirai: What are the effects of this problem on your life?

Mainini Shupi: The effects are many. My life is all upside down. Those questions about God are on my mind every day. Where is God in all my suffering? Does He still care for me or not? Most people when they look at me they think I am mad. I know because of ART, the virus in my body is under control but I am not. I believe in God. I may not understand what is going on in my life but I am sure one day I will understand and all the confusion will be gone.

4.4.6.6 Internalized homophobia as a symptom of spiritual pain

Mukoma T.J: I now live with regret thinking I should have been a better person and now I wouldn't be in this predicament.

Farirai: How do you mean?

Mukoma T.J: The real problem is self regret or rather self pity. I realize the errors of my life but I can't change that anymore can I? I really don't like myself at all and wonder whether God cares about me.

Farirai: What effect does this have on your life?

Mukoma T.J: I have difficulties in forgiving myself and I just feel God cannot forgive me and my wife cannot forgive me. Meaninglessness hovers over me every day and I wonder whether there is any point in living this life

Farirai: How is this working in your life?

Mukoma T.J: The truth is, this is not working at all and that's why I have this sense of meaninglessness.

Farirai: why?

Mukoma T.J: Because I know I am a better person. People make mistakes and if they can forgive themselves and others can forgive them, God will forgive them too. I don't know what I can do to forgive myself and for God to forgive me.

4.4.6.7 Guilt and guilt feelings as symptoms of spiritual pain

Mukoma Tippy: I am always confronted with guilt and guilt feelings. I must have done something. Why would I be in this situation?

Farirai: What is the problem you are struggling with?

Mukoma Tippy: I feel guilt as if I am being punished by God.

Farirai: How is the effect of guilt on your life?

Mukoma Tippy: Guilt has taken over my life. Who can explain to me why this is happening to me? I feel like a sinner no matter how much I have prayed to God for forgiveness I still feel unworthy of God's love.

Farirai; How is this for you?

Mukoma Tippy: As I said before. It's not working for me. Even in church when others are praising God I just feel like I am a hypocrite as if I am hiding something from God.

Farirai: Why is it like that?

Mukoma Tippy: I have been hiding this secret from people. I pretend to be okay when things are not okay. My marriage is terrible but I keep all that to myself. My wife doesn't accept me at all because of my condition. She makes me feel like I am the chief of sinners. My life is very difficult.

After deconstructing how spiritual pain manifests in all the participants, it became imperative to find out from the participants what they wanted. This is where, together with the participants, we identified the spiritual needs of people living with HIV and AIDS. Hence, in the next section I present the participants' spiritual needs, which became linked to "God only can heal" and this became the base for building the alternative stories in Chapter Five.

4.5 Spiritual needs of people living with HIV and AIDS

Then I asked the participants what they really wanted. The seven participants' different stories of pain and suffering seemed to converge into one. The seven participants agreed that they wanted to be healed from the spiritual pain. I then asked each one of them what this meant to him or her. Below is a summary of what each one of them stated.

Mukoma T.J

My spirit is wounded. I am in spiritual pain like someone with a physical wound. What I need is spiritual healing, which means to have my spirit healed so that I can have joy, peace and love in my life again. I want to laugh again. I want to love again. I know physically I am fine as long as I continue to take my medication. It is my spirit which is in deep pain and only God can heal me.

Mai Chipso

(Mweya wangu wakuputsika) My spirit is broken into pieces. I want my spirit to be restored. I want peace back into my life. I want to enjoy my life. This can't happen when my spirit is broken like this. I need spiritual healing which only God can give me. I want to know peace in my life.

Mainini Shupi

I am suffering from spiritual pain. HIV is under control because of the ARVs but my spirit is out of control. I want my spirit healed and I want the spiritual pain gone. I know that only God can

heal me. Everyone else has failed. But God can give me peace and joy. He can take the pain away.

Mukoma Tippy

This guilt I have carried for all these years since I tested HIV positive I want it gone. I don't want to leave like this anymore. I don't want to live with condemnation from other people and from myself anymore. I want to forgive myself. I want to feel forgiven by God and my wife and children. All this can happen when my spirit is healed. And I believe my help comes from God. He is the healer.

Mai Paida

What I really want is to move from anger and bitterness to a place of peace and happiness. My spirit longs to be in this space and I know it is possible through God. Only God can heal my wounded broken spirit and I will have that peace and happiness which I desire.

Mukoma K.K

My spirit needs rest. And only God can give me rest from all the pain within my spirit. God is the healer. He is the only one who can give meaning to my meaningless life. God can help me forgive the people who have hurt me in my life like that man who took my life. I have tried it myself for years and it hasn't worked out. Only God can heal me and restore. Maybe I can start enjoying my new marriage and find the courage to tell my children that I am HIV positive. Leaving with a secret is very difficult.

Mother

From all this pain and suffering what I really need is the healing of my spirit. HIV is under control although there is no cure for it yet but there is hope that one day they may find a cure for the disease. How about the spiritual pain inside of me which cannot be seen and yet it is destroying me? I have tried everywhere to find help but I think only God can heal me from my distress. I want to be whole again. I want to enjoy my children. I want to have peace and joy and to know that God loves me and accepts me.

4.5.1 Linking God to the spiritual needs of the participants: The unique outcome

In other conversations earlier on, I asked the participants who the why me questions were directed to and all the co-researchers affirmed that the questions were directed to God since everybody else had failed to answer their questions and only God can heal them. This stood out to be the unique outcome (1.12.4.10.2) from the problem saturated stories. I then became interested to find out, from the participants, whether the belief that God can heal the spiritual pain stood out to be something important to them and the answer was ‘yes’ because there is nowhere else they could turn to for help. I became curious to find out from them whether God the Creator/*Musikavanhu/Mwari* who they describe as almighty and powerful can become a personal God, who they could ask questions and expect God to answer and heal their spiritual pain. This unique outcome¹⁸⁹ became the base for chapter five.

As I reflected on how the co-researchers brought God into the conversations, I became aware of what Muller (2005:11) had earlier on observed that, “this is not a forced effort by the researchers to bring God into the present situation, it is an honest undertaking in order to hear and understand the co-researchers’ religious and spiritual understanding and experiences of God’s presence.” I connected this with how Heyns and Pieterse (1990:6) describe practical theology as that part of theology that concerns itself with encounters between God and humanity. On further reflecting on how God became linked to the spiritual pain by the participants, I discovered that it concurs with Louw (2000:21) who describes why as the anguish cry that encompasses all the sufferer’s distress, grief, pain and doubt. The distressed cry is directed to God for help and consolation. Louw adds that why, is an indication of the inner struggle with God’s justice in the midst of all suffering and an attempt to find a reasonable cause and resolution. This resonates well with social constructionist idea of resistance. Asking God the why questions was a form of resisting the spiritual pain. The challenge I now had was, can healing be discovered within the highly tense context of spiritual pain as experienced by the AIDS sufferers in Zimbabwe?

The seven participants made it very clear that their greatest need in this predicament was spiritual healing, to which they expressed that, only God can heal them. Their confidence and

¹⁸⁹ Freedman and Combs (1996:77) describes unique outcome as sparkling events that contradict problem saturated narratives.

belief in God as the healer excited me and I wondered how God was going to heal them? At this point in this journey with the participants, I realized that they knew what they really wanted. They requested for spiritual healing. They had made it very clear in the conversations that their pain was not physical but it was spiritual pain, which manifested in different ways. Hence, they needed spiritual healing to heal the spiritual pain and only God can heal them. I became curious to find out how people living with HIV and AIDS could use their faith as part of their healing process without any embarrassment as it were in the modern world, where faith was seen as something one settled for, when one could not have scientific evidence. I linked their belief in God as their healer with McLaren's (2000:178) opinion that "in the postmodern world, it seems, everyone lives by faith." From that moment in the research journey, God became the ultimate focus and an integral participant in the conversations, but it was not possible to control or pin down his/her participation. In such an approach, there was no need to come to conclusions and to define beliefs in a set of statements or doctrines. This gave birth to the re-authoring of the alternative stories in Chapter five where spirituality emerged as a hidden treasure within the HIV and AIDS pandemic, whose resources may benefit people living with HIV and AIDS in their quest for healing.

4.6 Conclusion

This chapter focused mainly on answering the first part of the research question. The seven participants were able to articulate that spiritual pain was the problem although it manifested differently in their lives. It also emerged that the participants although their stories of pain and suffering are different, their spiritual needs are the same. The spiritual needs are amply stated as spiritual healing to the experienced spiritual pain expressed in the spiritual outcry why me? The participants clearly stated that only God can heal them since everything else has failed. This therefore emerged as the unique outcome on which all their stories of indescribable and unimaginable spiritual pain converged for building the alternative stories which are re-authored in Chapter Five. The fact that the participants pointed out that only God can heal them from their predicament, indicated that spirituality within the postmodern paradigm can be a resource which can be used in supporting people living with HIV and AIDS on their personal spiritual paths to find healing. The participants in this research well articulated their quest for spiritual healing, hence the need for their spiritual well being is to be considered within the PHC delivery system

in Zimbabwe. The recognition by the policy makers that healthcare needs of patients has to be holistic and that it is the whole person to be cared for, for the best outcome for patients, exerts an expectation that spiritual care should also be incorporated into clinical practice in order to address the spiritual needs of patients. If this be the case, then surely it is the clinical staff that should be responsible for the patient's mind, body and spirit. Hence clinical pastoral caregivers emerges as the best clinicians to pastorally journey with the patients on their personal spiritual pathway to spiritual wellness and this is further developed in Chapter Five. My assertion based on this study is that, given that eighty percent of Zimbabwean people believe in God or higher power, ignoring matters of spirituality is disastrous to a holistic approach to care of people living with HIV and AIDS.

CHAPTER FIVE

A QUEST FOR SPIRITUAL HEALING: SPIRITUALITY AS A HIDDEN TREASURE

5.0 Introduction

This chapter focuses more on answering the second part of the research question having established in the previous chapters that people living with HIV and AIDS do have spiritual problems and spiritual needs. This chapter describes how the spiritual needs of people living with HIV can be addressed using a narrative approach within the primary health care delivery system. The goal of pastoral care was not to counsel or to take away the disease or to offer a ‘healthy dogs’- myths about quick fixed solutions and things that work¹⁹⁰. The aim of pastoral care was for me to mobilize the spiritual resources of the participants to enable the patients to cope¹⁹¹. The idea was therefore to empower those living with HIV and AIDS to discover their own inner potential, which would enable them to work through their spiritual pain. This was clearly not an easy task for both the participants and me but it carried the potential for growth and for healthier functioning in the present and gave perspective on a better future. The chapter also aims at describing how, we co-created a therapeutic framework in which those living with HIV and AIDS as well as those working with them be empowered to re-author the stories of patients’ lives around their self preferred images. The aim of narrative therapy in this regard is summarized by Muller (1999:24) as follows,

In this type of situation, therapy makes no sense, unless it can in the same way facilitate the hope for a better future. The pastoral therapist is challenged to help people dream dreams in the midst of hopeless situations and to imagine a future to allow them to sing a song again. Even though no change has taken place or no change can take place with respect to the situation, pastoral therapy will none the less seek to lead people towards the construction of a story of the future, which is realistic and make sense.

¹⁹⁰ Muller (1999:61)

¹⁹¹ Wittenburg (1993:61)

With this in mind, the re-authoring of alternative stories (see 1.12.1.3.10.3) based on the converging of the unique outcome “only God can heal” began to take place.

5.1 Re-authoring the alternative stories

The process of the re-authoring of people’s lives and relationships brings forth an alternative story (1.12.1.3.10.3). The alternative story is often anti-problem and brings forth people’s skills, abilities, competencies and commitments on their personal pathways to spiritual well being¹⁹². The participants understood God as the ultimate healer who becomes involved in human history and in their suffering¹⁹³. All the participants’ narratives had a cry for help in which, most of the time society and the medical doctors may ignore. My position as a pastoral caregiver was influenced by Henshousius (1994:15) who talks on how we should not only participate in constructing the alternative stories but also care in a way that heals and does not hurt. My purpose and desire of this research was to enable the participants discover new ways of authoring their lives through participation in the research as the experts of their lives. This is in line with what Collect (2003:22) affirms, that theological conversation should entail a “talking with” an “in there together “process in which the issues at hand are co-explored towards resolution and hope. This form of practical theology with its “from below “ communication style suggests that, spiritual information can no longer be passed down to people but that communication should involve the experiences and expectations of the people themselves¹⁹⁴.

I journeyed with the participants in the process of discovering spiritual healing and started to re-construct with the participants, their alternative stories in the context of their lives. White (1995:121) refers to this as the ethic of collaboration, the building of stories of hope in partnership with others. What is presented here is part of the participants’ personal spiritual pathways towards healing which is still work in progress using the narrative approach to therapy. In exploring how the participants’ need for spiritual healing could be addressed, I used the narrative approach as a possible approach through which a pastoral caregiver can be better enabled and equipped to work with, support and journey with the participants with greater insight, understanding, confidence and effectiveness. Not in the capacity of the expert or healer

¹⁹² Morgan (2000:59)

¹⁹³ Louw (2000:83).

¹⁹⁴ Rossouw (1993:900).

but as a companion on a journey towards spiritual healing. The paradigm I chose to work in leads to situating the work of research in a narrative metaphor and the emphasis is on possibilities that already exist in the experiences of the research participants, rather than on pathology.

In using narrative as a guiding metaphor, I wanted to create space for new knowledge, which would evolve from the story told so that the story teller and listener are involved in the construction of new meaning and understanding within the HIV and AIDS context. In other words, I also became part of that which I sought to offer, that is spiritual care. Freedman and Combs (1996:18) summaries this paradigm shift as follows.

Our experiences of the process that we call therapy have shifted as we have taken on narrative and social constructionist metaphor. We no longer organize our experiential worlds in terms of information and pattern. Instead we think in terms of 'stories'. Rather than 'system' we think about 'culture' or 'society.' Instead of seeing ourselves as mechanics who are working to fix a broken machine or ecologists who are trying to understand and influence complex ecosystems, we experience ourselves as interested people who are skilled at asking questions to bring forth the knowledge and experience that is carried in the stories of the people we work with.

On the other hand, the postmodern paradigm is also a shift from modernism where pastoral caregivers tended to think in terms of the help they gave as being viewed as expert of other people's problems. This according to Hoffman (1998:122) perpetuated a colonial mentality in the minds of researchers as they "tended to study/counsel down" people in that they chose to study societies and groups viewed as less civilized than their own groups. In the process of re-authoring the alternative stories, White (1995:36-37) indicates that we as therapists (pastoral caregivers) should move behind people who consult with us. White (1995:36-37) affirms that,

It's very easy for us to get ahead of the persons who seek our help. And persons can't see ahead with any clarity if we are standing in the way blocking their view. So it is more appropriate to be standing behind those persons or even perhaps alongside them, not specifically how things should be in their lives, not presenting a direction for their lives.

In line with these ideas, I was inspired to want to learn more from the participants and this was achieved by constantly checking with them on their comfort with the direction of our conversations, acknowledging their expertise and acknowledging the effects of the conversation on me as the researcher and pastoral caregiver achieved this. In this regard, the social production of knowledge became very important. This resonates with what Rosenthal (1993:59) stresses that, “the life story itself, seen as a social construct in its own right has increasingly become the focus of social scientific research.”

It became clear during the re-authoring process that within the social construction discourse, knowledge is therefore seen not as something that a person has but as something that people do together¹⁹⁵. If the knowledge of what people living with HIV and AIDS should be and do is a result of a social process and not an objective description of external realities, the opportunity remains for these people to socially construct new realities by negotiating meaning through language. The narrative ideas, which were used in this chapter focused on enabling the participants to begin re-authoring alternative stories based on the unique outcome identified in Chapter Four. In the next section, I elaborate and reflect on the unique outcome.

5.2 The unique outcome: Only God can heal

In this research, all the co-researchers affirmed that the why me questions as a summation of their spiritual pain were directed to God and their spiritual need was spiritual healing. All the participants stated that the unimaginable and indescribable pain which they were experiencing in their lives as people living with HIV and AIDS was in their spirits and they termed it spiritual pain. According to them, only God can heal their wounded spirits. Although the participants' experiences are different and the manifestation of spiritual pain is different, they all agreed that only God can heal them. The participants all expressed a belief in God as the ultimate healer of their spiritual pain. What the participants said agree with what Viriri and Mungwini (2009:185) observed about the Shona, that as far as the Shona are concerned, the full responsibility of all the affairs of life belongs to God. This is supported by Aschwanden (1987:13) who adds that for the Shona, God is the source of everything and that includes disease and death. Hence Saayman and

¹⁹⁵Burr (1995:8)

Kriel (1992:43) earlier on had indicated that for the Shona, since the primary cause of diseases is found in the spiritual realm that is where the means to heal are to be found. I became interested to find out from the participants how God was going to heal their wounded broken spirits. Their deep faith in God as the ultimate healer seemed to also suggest that, the participants had surrendered their fate to God. Total surrender meant seeking to have a deep intimate relationship with God and this became their spiritual reality, which they said will continue to guide them on their personal journey to spiritual healing even after the study is finished. Therefore, I was not only interested in merely listening to the telling and re-telling of the co-researchers stories, but I was also interested in the elements of therapy through which I could invite the participants to develop this sparkling event into robust, richly experienced narratives. I found those elements essential as I realized that, I was not a mere observer but an active participant. I didn't strive for solutions to the spiritual pain but tried to be part of the solution.

In this research journey, I was open to new ideas and views on God because I am convinced that each person's relationship with God is unique. Herholdt (1998:217) states that in postmodern theology, we need not be passive recipients of God's plan for us "all people are afforded the right to some human input that co-determines the plan for their lives." On the same note, Tong (2004:15) states that the potential for spiritual growth is so much greater when people actively engage in the spiritual meaning and making of experiences in their daily lives. I found Louw's (2003:193) opinion that, a response to the why me question does not primarily ask for a theological answer but makes an appeal for space and understanding of the questioner's relationship with God very helpful in assisting the participants to re-author their lives. Furthermore, Louw (2003:199) advises that, as pastoral therapists we need to ask, "how can we care and listen to each other not answer." Hence I found out that there was need to seek for a healing that was respectful, inclusive and communal. The participants viewed God as a healer. This appears to be a postmodern theology. Hence God became an integral participant in the conversations, but it was not possible to control or pin down his/her participation. I ensured that there was space in the participant's telling of God as they experienced their God. In such an approach, there was no need to come to conclusions and to define beliefs in a set of statements or doctrines.

Some researchers and writers have this to say about the Shona God. Mukonyora (1999:284) states that the Shona Christians have adopted the name *Mwari* as their God. Gelfand (1956:27) on the Shona religion have described *Mwari* as the “High God or Deity who reached such exaltation filling people with such awe” that *Mwari* became “an indifferent God too big, too almighty to be a personal God.” Bourdillon (1987:227) concurs remarking that *Mwari*’s interests are “too broad for him to concern himself with private individuals and their problems”. Murphree (1969:48) found that the Shona people refer to *Mwari* as a remote God, while the ancestors intervene in the day to day affairs of the individual and family. However, in this research, the participants realized that HIV and AIDS had become scandalous to the ancestors and had their hopes for healing in God.

Furthermore, Murphree (1969:48) adds that the Shona rarely speak about the high God and in most cases no attempt is made to communicate with him or to influence his activities either by implication or ritual. I became curious to find out from participants whether God the creator/*Musikavanhu* who they described as almighty and powerful can become a personal God who can heal their spiritual pain within the context of the HIV and AIDS epidemic. On the other hand, the Shona people used to pray to *Mwari* for rain and for liberation from colonialism could such a God also become personal to the AIDS sufferer to whom he/she can cry out for answers to the experienced spiritual pain? The answer to this from the participants’ perspective is an emphatic “yes” as they all echoed, “only God can heal since everything and everyone else has failed”. This stood out to be a unique outcome to build their alternative stories from all their problem saturated stories. Hence this empathic, ‘only God can heal’ became the base for co-constructing spiritual healing in the context of the participants’ alternative stories.

5.2.1 The Shona-Biblical understanding of God

Furthermore, the Biblical text of Genesis 1:26 states that God created man through his own image that man has dominion over the fish of the seas, the birds of the air and over the cattle and over all the earth including his own life. The same concept is prevalent among the Shona people. In Shona cosmology, for example *Musikavanhu* (Human creator) whom the Bible calls God created mankind, earth and everything in it. This affirms that in both the Biblical and Shona perspective, human beings were created as human beings by God’s will not by accident. Man

was also endowed with a divine spark that animates him with intelligence and the basic striving for goodness, perfection and understanding right from creation. This is to say that, human beings have the capacity to pursue the purpose of life on earth¹⁹⁶. For the Shona, *Musikavanhu* created life on earth by will and for a specific purpose. I wondered whether this could be the reason the questionings were directed ultimately to God by the participants who were experiencing spiritual pain. I was also curious to find out from the participants, whether this could be the reason why they had the confidence that only God could heal them.

I also realized that the question who is God to people living with HIV and AIDS becomes important in their quest for spiritual healing. In view of this assertion, the Shona-Biblical concept of God becomes a theological issue which needs to be reflected upon. In this regard, Louw (2000:12) argues that suffering as a theological issue signifies that people seek an explanation and a source of security that is able to carry them safely beyond the limits of this finite world. Hence the concept of God is important to the way in which one works through his/her spiritual pain¹⁹⁷. This ultimate question refers to the quality of relationship with whoever God is to the person and this was evident in the re-authoring conversations. This brought about the issue of spirituality, which seems to exist whenever we struggle with the issues of how our lives fit into the greater scheme of things, especially when our questions never give way to specific answers.

I also found this reflection by Nouwen (1987:20) insightful, that one of the ways God is revealed to us is as in relationship and therefore conversations with God are a source of personal and sound transformation which leads to healing. This was very useful in facilitating the emerging alternative stories. As I journeyed with the participants in re-authoring their lives, I became aware of Vest's (2000:1) assertion that, within the consciousness of all people is a yearning for life in its fullness and people want to be fully human and fully alive. HIV and AIDS often choke these desires. In the participants' struggle to find spiritual healing, what Merton (1960:395) said helped me, that, "we have a choice of two identities; the external mask which seems to be real

¹⁹⁶ Mawere (2010:277).

¹⁹⁷ Louw (2000:16) points out that during times of suffering the person struggles with the following questions. Why God? Who is responsible for my suffering? Hence this becomes the quest for understanding of God's identity in terms of explanations of suffering. All these questions revealed an attempt by the participant to link God to her/his suffering reflecting the link between theology and theodicy which seems to emerge whenever one attempts to articulate one's God image and test it in the context of concrete realities of life.

and which lives by a shadowy autonomy for the brief moment of earthly existence and the hidden, inner person.” Merton further explains that the false refers to the masks people wear and it is the obsessive and defensive self that wants to be independent of God. But the true self seeks union with God. However, what I experienced was that the participants in this study desired to be fully alive by being healed spiritually and according to them only God can heal them and it appeared as if their true selves sought union with God. The affirmation by the participants that, only God can heal their spiritual pain, concurs with Caputo and Scanlon’s (1999:11) who assert that, “in the modern period religion was ignored, not tolerated, repressed and (sometimes without reason) persecuted. But today, we witness a massive return of religion (spirituality) with all of its ambiguity together with a return to God to the centre of theology”. It is against this backdrop that this research wanted to explore, how the participants’ spirituality, could be utilized as a resource in addressing their spiritual needs.

5.3 Spirituality within the HIV discourse in the postmodern paradigm: a hidden treasure

This study was positioned within the postmodern paradigm and this shift did not leave out spirituality where the epistemic construction of God became local and not universal. Acknowledging these localized knowledges, Kotze and Kotze (2001:32) explain spirituality as being inclusive to include experiences and narratives people have about the other whom some call friend, God, Goddess, Divine, *Musikavanhu*(Human Creator) and as we do so, we enter the spiral of theological engagement by sharing the experiences and witness of those living with HIV and AIDS. My first language Shona refers to God as “Musikavanhu” Human Creator. The language acknowledges God as the deity that created everything with dominion over everything. The Shona knowledge of God becomes linked with action, which according to Ackermann (1990:33) becomes a focus for theological reflections and liberating praxis. In this regard, the participants were challenged to participate in the creation of a new world and not others creating for them. God was linked with the action of healing.

In conversations with the participants, what Herholdt (1998:225) postulates came to mind that, “every person imagines God personally and differently, although this does not exclude the religious feeling that my God is also your God.” Therefore, in order to enter the space of intercultural and inter-religious communication, it was necessary that “tolerance, mutual respect,

and even appreciation of the other be present.¹⁹⁸” This way of doing spirituality emerged as a resource for spiritual healing of the spiritual pain experienced by people living with HIV and AIDS. To the participants, this became a journey of self acceptance, self actualization within the core of God as the healer. As we journeyed on, I became aware that while HIV and AIDS is a horrific disease, it also affords an opportunity to rediscover the relevance and the power of spirituality.

5.3.1 Spirituality: Rediscovering a hidden resource

For a long time within the PHC system there has been an unquestionable acceptance of ‘expert knowledge’ which has its roots in the colonial era. Official knowledge has a history of being considered as scientific and modern developed as it were in European centres of knowledge. Patients’ knowledge has little room in the scientifically tested and proven body of knowledge. This study positioned within the postmodern paradigm attempted to emphasize the patient as a knower and the position of the thesis is that, no one is completely without knowledge but rather that, people may know different things depending on their social positioning and circumstances. There is also a two-way exchange of knowledge and information between those that were traditionally regarded as ‘knowers’ and those that were to be given knowledge¹⁹⁹.

Although the PHC delivery system has roots in religious and spiritual traditions, hospital care is often provided in a technological and spiritually barren landscape. Spirituality remains poorly understood and it is how this type of care is actually delivered. The spiritual dimension within the quest of healing has been consistently overlooked²⁰⁰. There has been a puzzling blind spot, a troubling silence and a strange consensus about the role of spirituality in the healing process of patients within the holistic approach to their care. This has had the effect of reducing intervention programs to purely medical, psychological and sociological²⁰¹. Now, this study sought to correct

¹⁹⁸ Schneitzer (2002:176)

¹⁹⁹ Woolgar (1983:244).

²⁰⁰ According to Hamilton (1998:276) research has demonstrated that the spiritual dimension of existence is an important and fundamental aspect of human functioning and also medical practitioners who take their patients’ spirituality into account can positively affect the healing process.

²⁰¹ Marty (1985:ix) makes this observation, “ just as pluralist and state universities squeezed religion out of the classroom, posted theology into satellite or alienated seminaries and sequestered spiritual care in off campus chapels, modern hospitals did not know what to do with the religious professional who embodied wholistic concepts of care.

such an approach by highlighting the role of spirituality based on a deep appreciation of the value of human life and a holistic understanding of the human person, in the healing of people living with HIV and AIDS suffering from spiritual pain. Sickness involves illness and disease. Treatment does not only include curing disease but must involve healing illness. Hoffman (1993:104) argues that diagnosing and treating people's problems as if they were medical events may be one of our greatest contemporary mistakes. On the same note, Thomson (1998:1444) made the following admission,

The reality is that science-based medicine can only go so far in caring for people. The unspoken scientific paradigm that permeates modern medical care says that everything can be explained by the scientific model if only we do more research. That is a flawed model. Everything cannot be explained. There is something more. It can be called faith and that is where spirituality is applied.

In addition, Foster (1982:246) states that the feelings and actions of many people are influenced by their spirituality and if the clinicians discount or disregard such views, the results can be disastrous for the patient and hospital. Foster (1982:247) adds that, "that is why the patient's views, regardless of how irrational, naïve or abhorrent, they may seem need to be treated seriously and compassionately and this is where the services of a pastoral counselor can prove invaluable." It is no wonder that patients and their loved ones desire the medical team to do more than just technically sophisticated treatment. There is also a need to be communicative and supportive. But clinicians are not trained to treat spiritual needs of their patients and this is where the spiritual caregivers can make a tremendous contribution²⁰². Some illnesses such as HIV and AIDS may prompt patients to ask serious spiritual questions like, why me and they may also muse over the fairness and justice of God. In the midst of their suffering, patients and their loved ones wonder whether they can find any glimmer of hope in their deplorable situation. To this end, Dolye (1992:302) candidly admits that physicians generally are hesitant to delve into the realm of the spiritual with their patients because they feel they neither have the time nor the skill to tackle this issue. Dolye (1992:303) adds that physicians feel inexperienced, untrained, unsure

²⁰² Foster (1982:250) note that "doctors are not required themselves to believe but need to know that others believe sometimes intensely.

and all too aware of their own spiritual doubts and questions and their sense of amateurism in the spiritual realm, is in stark contrast to their day to day professional confidence in their own discipline. Similarly, Wright (1998:82) notes that the nurses too are reluctant to get involved in the spiritual care of their patients because of lack of education in spiritual care, fear of invading a patient's privacy, lack of time and lack of awareness of one's spirituality. Hence Holst (1985d: 25) states the following,

The approaches to health care are broadening. There has also come an increasing recognition of the need for interdisciplinary understanding and interaction. As illness is now seen in more complex terms, so has followed the recognition that no one profession or method or service can independently or exclusively meet all the forces of illness... In many sectors pastoral care has won a place of relevance and respect in and by the clinical world.

I believe to be human is to be spiritual and to be in touch with one's spirituality involves cultivating an openness of mind a willingness to know, the courage to live with the mystery and the intention to embrace life fully. To be spiritual is to be inclusive, it is about stillness, practice and BEING, yet it is also about action in the world and about learning and sharing. Although spirituality is inherent in being human, it is always also seen as very personal and therefore different from one's religious beliefs. People could be spiritual even if they are not religious. With a background in psychology, the social sciences, counseling and theology, I am interested in the workings of the mind and spirit and know that sometimes it is better to stop the thinking mind diligently and respectfully. This bundle of ideas formed the ground or standpoint for my action plan as a pastoral caregiver, doing spiritual care with the participants in this study. In this regard a broader definition of spirituality would be appropriate.

On the other hand, historically, spirituality has had strong associations with illness and death²⁰³. Louw (2010:71) is of the opinion that spirituality has become an important topic with current practical theological reflection and one can even say that the realm of spirituality currently demarcates the field of pastoral theology. However, it should not also be surprising that

²⁰³Barney and Buckingham (2012:51-66)

spirituality has been associated with negative HIV and AIDS outcomes such as stigma and social exclusion, resulting largely from etiological beliefs concerning divine retribution and punishment. Spirituality is complex, a multi-dimensional construct which is almost impossible to define to anyone's satisfaction. Like love, most of us know it when we see it but putting it into definitions is cumbersome and elusive. However, we do need to have a rough map of the terrain and understanding of its boundaries and major landmarks, even if each personal journey through this landscape is unique, personal and different.

5.3.1.1 Definition of spirituality

Benor (2006:467) is of the opinion that there is no one definition of spirituality but descriptions of its characteristics abound in literature. Burkhardt (2007:263) states that trying to define spirituality is also akin to trying to lasso the wind. The wind is sensed and felt its effects on us. However I found the following definitions insightful to reflect upon in this study. Wright (1998:81) defines spirituality as,

The dimension of the person that involves one's relationship with self, others, the natural order and a higher power manifested through creative expressions, familiar rituals, meaningful work and religious practices. It also involves finding deep meaning in everything including illness, death and living life according to a set of values. Spiritual care involves helping people identify and develop their spiritual perspective and personal awareness of spirituality and its components.

Spirituality has been referred to by Culliford (2002:1434-5) as, 'where the deeply personal meets the universal, a sacred realm of human existence.' To describe spirituality as linking the deeply personal with the universal, is inclusive and unifying and it implies to everyone including those who do not believe in God or higher Being. The universality of spirituality extends across creed and culture, at the same time it is unique to each and every person. In other words, what I observed in the process of co-creating spiritual care with the participants was that, spirituality is that faculty present in all human beings which causes them to search for meaning in what is happening to them to attempt to make sense for themselves. Spirituality is a label strategically deployed to extend the realm of relevance to any person's belief system, regardless of his/her

religious affiliation. Spirituality aims both at inner growth and outward manifestations of this growth. Spirituality is the experiential integration of one's life in terms of one's ultimate values and meaning without the institutional element connoted by religion in order to defuse the tensions that accompany a denominational or even religious identity. Spirituality refers to experience associated with the relations with the Supreme Being, which can be described as transcendent or transpersonal in nature²⁰⁴. How the sacred interacts with human existence. Spiritual resources are practices, beliefs, objects or relationships that people turn to for help in times of crisis e.g. music, prayer, meditation, family and friends, religious leaders, church, synagogue, support groups, Bible, Koran or Torah. These resources can be helpful to people in the process of re-authoring their lives. The next section describes how the alternative stories of participants were re-authored using re-authoring conversations (1.12.1.3.10.3). I elaborate below on the reauthoring conversation maps used in this process.

5.4 Re-authoring conversation map

Furthermore, Russell and Carey (2004:75) state that there is a re-authoring conversation map that acts as a guide to re-authoring conversations. The re-authoring conversation map divides the questions that we ask as researchers into two categories; landscape of action and landscape of identity of the preferred story²⁰⁵. Landscape of action questions involves inquiries into events, beliefs and actions. For example I would ask the participants questions like.

- When did you realize that God can heal you?
- What happened before that?
- Have you believed this way before or was this the first time?
- What do you think made it possible for you to believe that God can heal the spiritual pain?
- Do you think that despite the effects of the spiritual pain you are able to believe this way?

²⁰⁴ Louw (2010:75)

²⁰⁵ Moran (2000:68)

In asking these questions, I was trying to draw out more information about the belief that God can heal and the participants' understanding of the healing process. Here are some of their responses.

Mai Chipso

I think I started realizing that our only hope is in God during our meetings here. Every time we would come together and listen to each other's story of pain and the experiences we have all gone through I started asking myself, who else can help us in this suffering except the one who created us. I used to believe that God can heal us but I thought that he could only do it through the faith healers. But throughout our conversations, I have realized that we cannot put all our trust in the faith healers. They are also humans and their powers are limited. What we are experiencing in our lives because of HIV and AIDS can only be addressed by God. Despite the spiritual pain I am experiencing I know God can take the pain away. He can give me peace in my despair.

Mukoma T.J

I came to realize that only God can heal me a few weeks ago during the course of our conversations here as a group. One day after we spoke about the traditional healers, the prophets and the medical doctors having failed to assist us with the spiritual pain we are experiencing, I started asking myself who else can we turn to? As a Christian, when this thought came into my mind I wasn't convinced God can take the pain away. But then I said who else can when everyone else has failed? Then I became convinced that surely only God can heal my broken spirit.

Mother

For me, it hit me the other day during our group discussions that God is our answer. It seemed that because of the effects of spiritual pain on my life, I had forgotten completely what God can do. I just remembered that only God can heal us. Thank you Farirai, for helping us to remember God as our healer.

Mainini Shupi

For me to believe that God can heal me came to me as a shock one day after our meetings. I sat on my bed going over what we had discussed that day, trying to find a solution to our problem. Then it hit me. Only God is our helper. Everyone else has failed. We have tried everything and we have come to the end of ourselves. Where else can we turn to except to God? From then on it became clear in my mind that yes, God is our healer.

The process of re-authoring conversations assisted the participants to link various events into alternative stories. Landscape of identity or meaning questions relate to the implications that the alternative story has in terms of the person's identity²⁰⁶. They invite people to reflect differently on their own identities and that of others. The landscape of identity questions encouraged the participants to explore a different territory. They related to the implications that the alternative story line had in terms of the person's understanding of their identity. For example, I would ask the participants questions like:

- What did it take you in order to believe that God can heal you?
- What did it mean to you to believe this way?
- Have you ever believed this way before?
- The belief that God can heal the spiritual pain, what does this say about you as a person?
- What does this say about your hopes for your life?

Some of the participants responded this way.

Mai Paida

It took me everything called me to believe it. It meant that I have to totally surrender my life to God. I have to work on my relationship with God and this can only happen when I walk closely with Him and to start hearing Him talking to me again directing my path as before. I used to have a very close relationship with God before I became HIV positive and I know I can have it

²⁰⁶Russell and Carey (2004:23).

again if I can only allow him back into my life. My hope is that one day I shall be healed and all the spiritual pain in my spirit will be gone and I will be at peace with myself, with God and others. I hope that I will be able to forgive my husband and love him once again. Then I will encourage others to trust in God as the healer of all our sorrows. I hope that one day I will be able to talk to others who are experiencing spiritual pain and encourage them to trust God as a healer. My life will be a testimony to others of God's healing grace.

Mainini Shupi

It took me a long time because I have never thought that God can do this for me. Being in this group has changed that completely and I now know it that God is the healer of this spiritual pain. It may take time but I am happy that I am on the right path to healing. I know that my relationship with God is very important in this regard and total healing also includes other relationships I have with other people and even with myself. I am a determined person and I know if I set my mind on something I will do it. I am prepared to do anything to work on my relationships. My dream is to be trained as a pastoral counselor so that I can help others effectively in a non-judgmental way.

Farirai: MukomaTippy what did it take you in order to believe that God can heal you?

Mukoma Tippy: It has taken me a long time to actually believe that only God can heal me. I don't think if you had not come here to talk to us I could have started believing this way. I think I have now come to the end of myself to believe this way. I have always known about God in my life. I have been a church goer as long as I can remember. I have actively been involved in church activities ever since but I had never been so desperate for God like this. So in other words, it has taken me to be HIV positive to believe that God can heal.

Farirai: What does it mean to you to believe this way?

Mukoma Tippy: To me it means that I know it in my spirit that God is a healer and I believe that I will be healed one day. All the spiritual pain will be gone and I will be myself again. I will have peace and joy back into my life even if I am HIV positive. The HIV will be there but as long as my spirit is in the right, place everything will be alright. And I will be able to cope with the virus better.

Farirai: Have you ever believed this way before?

Mukoma Tippy: For me this is my first time to believe that God can heal the spiritual pain inside of me. In my life, I have never gone through anything I can compare to this pain. But being in this group and listening to each other's stories and talking to you, I have become convinced that our only hope is in God. I am now realizing that the HIV experience has become a doorway for my spiritual growth.

Farirai: The belief about God healing the spiritual pain, what does this say about you as a person?

Mukoma Tippy: To me this means, I am a very determined person and I will wait on God to heal me. It also means that I know what I want and I will do what it takes to work on this. I know this is the beginning of a long journey to wholesomeness but I am committed to my belief. I don't know how God is going to do it but I trust him to do it. Already by being in this group, I feel different about the spiritual pain and that is a good sign. I am now on my way to healing.

Farirai: What does this say about your hopes for your life?

Mukoma Tippy: I know that God is a healer and I believe that I will be healed. I believe that I have a purpose and I am not leaving this world until God has finished the purpose that He has put me here for. Maybe one day I will receive training, just like you Farirai and I will work with other people who are HIV positive who are experiencing spiritual pain.

Landscape of action and identity questions were very useful and helpful in the development of the participants' new stories. The questions led to an exploration of the participants' values, commitments, beliefs, desires, intentions and strengths. These were articulated and brought into the foreground of an emerging alternative story while the dominant problem saturated story was placed at the background. The questions brought forth a rich description of the participants' abilities to act in relation to the problem's influence on their lives. The questions re-invigorated people's efforts to understand what it is that was happening in their lives, what it is that happened, how it has happened and what it all means. The scaffolding provided by the questions of re-authoring conversations made it possible for the participants to address and to fill the gaps in their alternative landscapes of the mind. I weaved these questions back and forth in and out

assisting the participants in creating a new and different story. Most participants spoke about their hope of becoming agents of transformation, advocates, peer educators, pastoral counselors and trainers of people living with HIV and AIDS. Hence it became imperative to assist the participants to find ways of holding onto their beliefs and in narrative therapy, this is called thickening the alternative stories.

5.5 Thickening the alternative stories: Witnessing and expanding conversations

As the new and preferred stories of the participants began to emerge, I became interested in finding ways to assist the participants to “hold onto”²⁰⁷ or stay connected to the emerging stories. Morgan (2000:74) points out that one way of doing this is by thickening the alternative stories which involves finding witnesses to the emerging stories and this can be done through re-membering conversations (1.12.1.3.11.5), outside witnesses (1.12.1.3.11.5) and later by expanding the conversations using rituals and celebrations (1.12.1.3.11.5). There are also other options for thickening the alternative story that do not necessarily involve people such as documents and letters. Morgan (2000:75) is of the opinion that all of these options can play a part in creating a richer description of the alternative story and this in turn can assist people in staying connected with the new preferred story. Together with the participants we agreed to use; re-membering conversations and outside witnesses to thicken the alternative stories of the participants. These practices were identified in chapter one (1.12.1.3.11.5) but I will elaborate on them in the following sections.

5.5.1 Re-membering conversations

Re-membering conversations are one way of thickening the preferred story. Re-membering conversations as a way of developing further the alternative stories is based on the assumption that, there are people who had particular parts to play in how we have come to experience ourselves. These people form a club of life. Some influence our identities positively and some not so positively. Re-membering practices are based on the postmodern understanding that, our identities are forged through our relationships with other people and one’s life has membership and this membership influences our experience of ourselves. How these others see us, how we

²⁰⁷ Morgan (2000 :74)

experience ourselves with others influence who we are becoming as people. This can be summarized as ‘people becoming people through other people.’²⁰⁸ The idea about the social construction of identity fits with the idea of ‘ubuntu’ as described by Mbiti (1998:143), “I am because we are and since I am we are.” which honors the connections that people have with others in a way that fundamentally challenges individualistic ideas of Western therapy.

In the Shona spiritual worldview as noted by Shoko (2004:6), the Shona also believe in the anthropocentric worldview that places the human being in a central position in all cosmology. *Munhumunhu* – A person is a person, meaning no one should look down upon others. In fact everyone whether rich or poor, physically challenged or otherwise has a duty of service to make the world a better place to live. The Shona philosophy has been captured, though implicitly by Mbiti (1969:145) describing the African view of a person as he notes that, this can be summed up in the statement “I am because we are since we are therefore I am”. This dictum confirms that personhood in the African contexts is defined by reference to other members of society both the living and the living dead. Christianity shares with the African culture the view that humanism is central to human co-existence. For example, the use of “*mukoma*” brother for everyone older than them even if the referent is not related to the former. This strongly resembles the terminology of the early church in the New Testament where Christians called each other brothers and sisters.

This is also a view of life that sees our identities as being made up of many voices, multi-voiced and is quite different from other highly individualistic accounts of identity that focus only on a single voiced self. It is also distinct from contemporary structuralist understanding of identity that constructs a ‘self’ at the centre of one’s being, comprised of various properties and essences of the person’s nature. Re-membering conversations do not assume an individual ‘self’ but rather an interconnected web of relationship. Hence, relationships create us rather than ourselves create relationships. Re-membering questions helped to link the life of the participants with the life of another person around a particular shared value or belief like in this case. And the remembering questions helped to build upon the beginnings of an alternative story. When the participants started to glimpse an alternative way of thinking about themselves I assumed that there were

²⁰⁸ Morrison (2002:5)

traces of these preferred identity claims that reached into the person's history and that there would be some person or figure who would have contributed to these preferred claims. I was therefore interested in asking questions such as these ones below. These re-membering questions evoked the views and perspectives of people who could contribute to the further development of the alternative stories and in this case "God is the healer." The linking of lives across shared themes is a key aspect of re-membering conversations. Once people's lives are linked around a particular theme, this often reduces a sense of isolation and contributes to a richer description of the alternative story of a person's life. This is because people's abilities, commitments, beliefs and purposes are not created in a vacuum. They have been shaped by the person's history and relationships with others and the world. It is simply a matter of us finding ways to unearth these connections and histories. It is worth mentioning that re-membering conversations do not only involve considering those who are alive. Hence, through re-membering conversations I offered conversational skills that worked with the local knowledges and resources of the participants and community to which the client belonged. This opened more possibilities of taking the work beyond the limitations of the consultation room and therapeutic conversations. Narrative practice is based upon the belief that one's sense of self is socially constructed and exists in relationship to others.

I asked the participants questions such as:

- And how do you think you came to believe that God can heal you?
- What is the history of this belief?
- This belief that God can heal the spiritual pain, is there anyone who would not be surprised to hear you talking like this?
- Or is there someone who introduced you to this idea of believing in God as the healer of spiritual pain?
- If so why do you think they encouraged you to do so?
- What do you think they would say if they were here with you now?

- How would they say it?

Below are some of the participants' responses to the above questions.

Mukoma K.K

My late grandmother would not be surprised to hear me talk like this. I grew up with my grandmother and she was a wonderful Christian woman. She taught me how to pray and to believe in God. We lived in the rural area and there were so many stories about witches and so forth. But my grandmother would believe that God was able to protect us from those witches. This idea about God being the healer of our predicament just came during the course of our meetings as a group. Now if my grandmother would be here with me she would be so happy and excited to hear me believing God this way. She would be so proud of me and would say, "My grandson, God is the answer to all our problems and if you can only believe all things are possible."

Mainini Shupi

For me it will be my friend who is also HIV positive. My friend has been talking about putting all our trust in God for a long time. I have always wondered why my friend is always happy and carefree and every time I would ask her she would say it is because of her faith in God. I never took her serious until I became part of this group. Slowly as I listened to each other's story, I came to realize that God only knows why we are in this predicament. If my friend would be here listening to me admitting that God is the ultimate healer, she would ask me what has happened to me to change my mind. I would tell her that this group, helped me to see things more clearly and I am so happy I have decided to follow this path.

Mukoma T.J.

My uncle would not be surprised to hear me believing this way. He has faith in me in that if I say I am going to do something I will do it. We had an experience together with my uncle when we were growing up. We were very poor and money for school was not always there. When we were in form four, we didn't have money to pay for our exam fees. So my uncle said to me lets believe that God is going to provide for our fees. At first I didnt believe that. But he kept on

encouraging me and talking about the stories of how God helped the Israelites to cross the Red Sea. It was my first time to hear such stories. On the last day before we were sent back home, a miracle happened. My uncle's aunt who had come from the UK decided to come to school to pay him a visit. She brought him very nice things. Then she gave him pocket money which was enough to pay for his fees. Then my uncle remembered me. He told his aunt about my predicament. She opened her purse and gave me the money. We were so happy. And my uncle reminded me of how God can help us in times of distress. So if I were to tell him now that I believe God can heal me, He will be so delighted and He would want to journey with me on my spiritual journey to healing. I think He would say, "God is with us, in good times or bad; in health or sickness; in strength or weakness. We may have to endure many things in this life, but we do not have to be lonely. God has promised to remain with us forever and ever-- in this life and in the next. We are not alone." I had never told him that I am HIV positive but now that I have this courage, I am going to tell him and I am sure he will be there for me.

What some participants said here agrees with Louw's (1994:1) affirmation that the patients, "will view their illness as a very special opportunity for growth... to create a new understanding of their calling in life... a calling and responsibility within a living relationship with God and a loving relationship with fellow human beings."

5.5.2 Outside witness

In narrative therapy practice, an outsider witness is an invited audience to a therapy conversation. It is like a third part who is invited to listen to and acknowledge the preferred stories and identify claims of the person consulting. Outsider witnesses may be part of the person's existing community²⁰⁹. Problems are often extremely successful at separating and isolating people from others and so, a key aspect of re-authoring conversations is to open spaces of connection and reconnection²¹⁰. The participants themselves became the outside witnesses to each other's story and they offered reflections as to what it means to hear each other's commitments, faith and belief and how their stories have touched each other's stories. Relationships play a very vital role in the management of spiritual pain of the patient hence, friends and family may help as it is a

²⁰⁹ Carey and Russell (2003:2)

²¹⁰ White (2007:127; 165-166)

normal human activity, which takes place on various levels anything from a hug, holding hands, empathic, listening, a prayer, a gift or even massage. Need for love and harmonious relationships go hand in hand with the need for meaning and purpose.

Carey and Russell (2003:2-3) explain that having outside witnesses in therapy means that the steps that a person makes in therapy can be translated into action in their daily lives. Outside witness practices enable a link to be made between what happens in therapy and the rest of a person's life. The sense of 'realness' or 'authenticity' only comes, when the preferred stories are witnessed and responded to. Recruiting some of the audience to the preferred developments is also powerful and authenticating. Myerhoff (1986:25-40) posits that outside witness groups side with the person and support the person. Weingarten (2000) refers to a team participating in the above manner as a 'compassionate team' which emphasizes the team's compassion and support. White (1995:178) says the outside witnesses contribute to the affirmation and authentication of people's claims and about their identities, narratives and their appropriation. White (1995:178) continues saying that,

It gives greater public and factual character to these claims, serving to amplify them and to authorize them. The outside witness also contributes to a context for reflexive self consciousness in which people become more conscious of themselves as they see themselves and more conscious of their production of their lives. The achievement of this reflexive self consciousness is not insignificant as it establishes a knowing that, 'knowing is a component of their conduct making it possible for inventing themselves and yet maintain their sense of authenticity and integrity for people to become aware of options for intervening in the shaping of their lives.

In addition, Morgan (2000:121) points out that, outside-witness groups are made up of two or more people known or unknown to the person seeking help. In this study the group members became the outside-witnesses to each other's emerging preferred story. The conversations between the members of the outsider-witness group are guided by the principles, ethics and practices of narrative therapy. Their retelling takes the form of a dialogue, questions and comments flowing freely between the members of the group. These retellings contribute to a rich description of the conversations that have just been witnessed. They achieve this rich description

by focusing on the emerging alternative stories of people's lives and on the unique outcomes that were identified before. The participants in this study as the outside witness group asked each other questions about anything that caught their interest, comment on events that they were curious about and expressed curiosity about aspects of the conversations that they wanted to understand. The group members also explained why certain parts of each other's story touched their lives, or reminded them of someone or something which also happened to them or something they read. In doing so, the group members shared the responsibility of recognizing how what they had heard resonated or connected with their experiences, or with their own commitments or beliefs.

For example, after listening to Mukoma T.J's story, some of the group members responded;

Mother:

What Mukoma T.J said about God being with us reminds me of a story I read about trusting God to be there for us all the times because he loves us. God is love. God's love is extended to all people. It has no end and is unconditional. God's love has no "ifs, ands, or buts." No one and nothing can separate us from the love of God that is in Jesus. We are all precious to God. Jesus lived, died, and was raised from the dead in order to demonstrate God's love for us. Our love for God is demonstrated by our loyalty to Jesus and our love for one another. Even when we feel unloved or unlovable, at the back of our minds we should remember that God's love is constant. Even when we disappoint ourselves, God continues to love us. Even when others turn their love away from us, God's love for us never waivers. We should also go and read in our Bibles these verses John 3:16-18; John 10:27-29; Romans 8:35-39; I John 4:7, 8 HIV often makes us feel separated from others-- our families, our friends, our partner, even God. The Scriptures assure us that nothing can separate us from God's love-- not even HIV. In the midst of the challenges of HIV/AIDS, we can be assured that God still loves us. God accepts us right where we are. That does not mean that God approves of all we do or that God is willing to leave us just the way we are. It does mean that God's acceptance is unconditional. We are loved!

Mukoma K.K

As you were talking about your uncle, it started something in me. I was just wondering Mukoma T.J when was the last time you saw your uncle? Why I am asking is that because people change.

I don't want to discourage you but I had a very bad experience with my uncle whom I trusted so much. But for some reasons he has let me down so many times. Maybe yours is different and I wish you well. But in case when you go and see him and he doesn't respond to you in the manner you expect, forgive him and move on. You said you are very courageous and we have witnessed that in this group don't give up People sometimes break their promises, destroying our faith in them. We may become so disappointed in the actions of others that we begin to give up on people. When the people who hurt us are members of the religious community, we are tempted to give up on religious institutions and people. We can even be tempted to give up on God like how I felt when we began this journey. Some clergy and congregations fail to meet the needs of people. However, millions of people, including those whose lives have been touched by HIV/AIDS, have found parts of the Christian community to be very supportive. We all need spiritual moorings, to feel connected to something greater than ourselves. We all need to feel like we have a place in eternity. We want to experience love, peace, forgiveness, and hope. We lose all of these benefits if we react to the uncaring acts of others by shutting down our spiritual life. People will sometimes fail us, but God will not. God is always greater than the people who claim God's name. Even if we have given up on people, we do not need to give up on God. God never gives up on us.

Mukoma Tippy

What touched me in your story is what you said about God being with us all the time. What I want to add is that God desires intimate contact with us. God wants to hear our concerns, fears, hopes, dreams, and questions. God wants to cry with us and laugh with us. God wants to hear our prayers and to talk with us. When HIV touched our life, we experienced the end of some relationships. Because we do not want to be hurt again, we can become reluctant to reach out to others. God wants us to take the chance and reach out. God will never hurt us. God will never turn away from us. God will not cut off our spiritual relationship with Jesus Christ. We can be sure that if we reach out to God, we will find that God is already reaching out to us. If we draw near to God, God will draw near to us

Mainini Paidia:

What I connect with is that HIV affects the body but hope is found in the spirit. We hope for spiritual healing. We hope that we can fulfill our dreams. We have hope, that after we take the step of death, our story will not end. In fact, our hope says that our existence is eternal and that one day we will be in a place with no death, illness, or tears of pain. Scripture calls us to rejoice at all times. While we do not rejoice about the negative things in our life, we do rejoice that God goes through these things with us. We rejoice that the love in our hearts will last forever. We find joy in the faces of children, in the little things of life, and in the kindness of loved ones. Without peace, hope, and love, life is unbearable. With them, we can live and thrive.

About the group being witnesses to the new identities of the other participants, Mai Chipso said,

To be witnesses of our new stories is a way of showing how committed we are and that we need other people's support in our preferred ways of living. And to hold on to the belief that God can heal us of this spiritual pain, we need the support of one another to keep on holding on to the hope of a new life.

Mukoma K.K also said,

Being a witness to each other's new stories is very encouraging because we know where we started and during the journey we all have seen the changes which took place. We have been there for each other and this means we continue to need each other's support. Even after the research is over, we will continue to meet or call each other to encourage one another not to give up hope.

5.5.3 Expanding the conversations

At the beginning of the research journey, the participants gave a name to their group. Towards the end of the research journey the participants mapped their way forward about the group **Gweru "Rudo Chete" Association**. "Rudo Chete" means "Love Only". This will link the participants together even after the research journey so as to support and encourage one another to continue re-authoring their preferred stories around certain beliefs, values and themes as well as stand together against certain problems and contribute to their activities and events. This was in line with what Morgan (2000:116) advocates,

Many narrative therapists try to find other ways to assist people to access the special knowledges and understanding held by others. Establishing and consulting leagues, communities, teams, groups and networks constitute one way this can be done. These leagues are groups of people interested in sharing their inside knowledges with others. They bring together and circulate voices of people who are involved in a similar struggle. In this way, it is their voice on these matters that are privileged, rather than the voices of therapists.

The participants asked me to be their consultant and I agreed with great pleasure because it opened up an opportunity for me to keep in touch with the participants who have become part of my life. They are determined to work together and to work with other people living with HIV and AIDS who are still experiencing spiritual pain. They also want to work with the community as peer educators, facilitators and trainers in HIV and AIDS. They have also requested me to train them in basic skills in spiritual care and counseling to which I also agreed. I was really touched by their commitment to their new ways of living. I never thought or imagined that the participants would form an association like this one. I expressed my excitement to them to which they stated that even though we were celebrating the end of our research journey together, they would continue to meet in future to reflect together through preferred ethical ways of living. They also indicated that in their future meetings they will continue to share their experiences of living with HIV and AIDS, counsel each other and empower each other. They also mentioned that they would also want to celebrate their lives together as a group.

5.5.3.1 Rituals and celebrations

Celebrations, awards and prize-giving signal a shift of therapy from problematic relationships to the positive steps taken. The participants planned a celebration ceremony at the end of the research journey and it took place at the lecture Hall at the Hospital. The matron in charge of the Opportunistic Infections Clinic was the guest of honour. Mukoma Tippy was the master of ceremony. Mother and Mai Chipu prepared the songs and the prayers. Mukoma T.J and Mukoma K.K prepared the room and decorated it with beautiful flowers and cloths. Mai Paida brought us some drinks. I provided chicken, salads, rice and some fruits to help create a celebrating atmosphere. Before the celebrations we had some reflections on the research journey in the midst

of tears and laughters. Each participant had prepared a metaphor(s) as a symbol for the growth she experienced on the journey together. The following are parts of the reflections.

Mai Paida

When we began this journey, I was like a small reed in a flooded river. I wasn't sure I was going to survive. I felt like the river was going to drown me. I had so many overwhelming problems. Remember I told you that sometimes I also felt I was mad because people treated me like a mad person because I take tablets every day. I had so many relational problems. I had never disclosed my HIV status. But since the first day of our meetings I sat and I listened to other people's stories of pain and suffering. I was encouraged to also share my story of pain without shame and this was my first time to disclose my HIV status to anyone besides my husband. From that day you remember how I used to cry. But now my story is different. Being in this group has helped me. I have disclosed my HIV status to my mother and father without feeling sorry for myself. I have encouraged my husband to test for HIV and he went for the test. In fact I went with him. He tested positive and he has already started on ARVs. My whole perspective on life has changed. I am happy and I can't stop talking. I know I am on my way to spiritual healing. Spiritual pain will no longer control my life. The spiritual healing may take time but I know God will do it one day.

Mother

To think of where I was before this research journey it's unbelievable. I was like someone walking on top of burning coals without shoes and the journey was becoming long and wearisome. I was on the verge of a breakdown. I can never thank you enough Farirai for coming to us at the right time. You were God sent. I thank God that you found me before I went crazy. But now my story is different. Now I see myself as a baker using the red coals to bake bread and share with others. I see myself reaching out to others who are still where I was. You know the change in me cannot be hidden. I have heard many people come to me asking me whether I have won some lottery money because everything has changed. I now have a different perspective on life. Already so many HIV positive people have come to me to inquire about the change in me and I have told them my testimony. I now have a testimony about the story of my life. I can now

share it without shame. I know I am not done yet but it shall be done. The spiritual pain will one day be completely gone by God's grace. I am on my way to healing.

Mukoma T.J

I was a condemned man. I just saw myself as a crazy man who married a woman without telling her I was HIV positive. There was no sentence to such actions except to be hanged. The confusion was too much. I remember the first day I met Farirai I had come with my wife because she just wanted to see what it was like at the hospital. My wife had been sick but she was refusing to test for HIV. I asked Farirai to counsel with her. After that counseling my wife went for testing and now she is on ARVs. Now we support each other and she has forgiven me. I have also told my family about my status so that they can stop worrying us about having children. Now that everything is in the open we are happy and we are taking care of each other. Things have changed for me. I now believe that God will take away the spiritual pain and healing is on the way. In God's time everything will be alright. Sometimes these days I try to search inside of me for the spiritual pain and I don't feel it and I am like how can that be. I have lived with this pain for years. But I know God is working inside of me and one day I will have my life back again.

Mukoma K.K

Hopelessness, powerlessness and doomed to die is all I could see and breathe. I saw myself as a chicken vulnerable to the eagles because of my experiences with women and HIV. At the beginning of this journey I was bitter because a policeman took my first wife. Something happened the other day. I met this policeman when I went home for the weekend. Usually every time I would meet him I would shout at him and call him names. But this time it was different. I saw him first before he saw me. I suddenly remembered this group and I said to myself, if they would hear that I shouted at this person what would they say? I changed my mind. I felt something move in my spirit. I just couldn't shout at him. I am a changed man. At home we have told the children about our HIV status and now they buy us a lot of food. Look I have put on a lot of weight. They are very supportive. And to my new wife, I love her and we are happy something I never thought would happen. I now see myself as an eagle flying higher and higher every day

because I know I am on a good path. As long as I keep on believing God will come through for me one day.

Mainini Shupi

My life was just nothing before the research journey. Inside of me was empty. I had no hope and no purpose. My problems were very many. I had forgotten how to live. Everywhere I turned there was no hope for me. HIV had overtaken my life completely. I didn't know what to do. I saw myself as a lost child in a dark forest far away from home and I didn't know which way was home. But now I know my way home. It may take a bit of time but the good thing is. I am on my way to healing. You can all see how bubbly I am these days. My husband seeing all these changes in me went for testing and he is now on ARVs. After our meetings he asks me what we have learnt and he is also asking when he will join the group also. We are working on our relationship. At work they have also seen that I am a different person as well. I love the person I am becoming and it seems other people do as well. I went home to my mother and we spoke the whole night about my life. She just assured me of her love and she wished I had come to her earlier. We are working on our relationship and with God's help it shall be well. I am so happy that I became part of this group.

Mai Chipso

You remember my friends that I wanted to run away from my husband and go to work in South Africa. So, when I saw Farirai and she said she was from a university in South Africa, I thought this was my chance now. I was like a fly caught in a spider web and didn't know how to untangle myself. God sent you Farirai and I hope God will give you more opportunities to work with other people who are HIV positive and experiencing spiritual pain. You have helped us to see things differently. I am not running away from my situation anymore. If you run away from something it will follow you. I now have the courage to face whatever comes my way. I now believe in God so much. My perspective on life has changed and even my speech has changed. My mother noticed and she asked me. I told her about my hope in God. She was so excited and she prayed for me. As for my husband we no longer fight a lot. We are working on our marriage. The other day we

were discussing about making an appointment with Farirai to help us in our marriage. To be part of this group has completely changed my life.

Mukoma Tippy

The story of my life was very sad and painful. I had never had a chance to talk or tell the story of my life until the day I became part of this group. At first I wasn't sure I was going to be able to say something but when I listened to others telling their stories I felt empowered to share mine. As you all know my story was a story of pain and shame. Guilty and condemned to die was written on my forehead but now as I speak many good things have started happening in my life. I am no longer angry at my wife when she tries to make me feel guilty about being HIV positive. I find joy spending time with my boys. My whole perspective on life has changed. I am still a deacon at church and do my duties without any remorse. I joyfully serve the people of God. I now live like one who has been forgiven. We talk a lot now with my wife. I don't run away from home as I used to. I have the courage to face her and talk openly about all these issues. She also has noticed the change in me and she is changing as well. We now can laugh together, a thing we had completely forgotten about ever since HIV invaded our home and marriage. I am convinced that we have started on a new journey to healing and God will heal us. I have the hope that one day; I will also start a support group for discordant couples here in Gweru. I want to thank you all for this support.

The matron presented the certificates to the research participants (Appendices F and G). The first certificate was the membership certificate for the **Gweru Rudo Chete Association**. Their motto is. **Rudo runokunda zvose** meaning love conquers all. The next certificate was of acknowledging their knowledges and understandings of experiences of spiritual pain experienced by people living with HIV and AIDS, their spiritual needs and the quest for spiritual healing. These knowledges and understandings acquired during the research process have the potential to assist and support other people living with HIV and AIDS who are questing for spiritual healing.

5.6 Reflecting on the emerging spiritual care

A strong suggestion that emerges from this research is that spiritual care of persons living with HIV and AIDS who are receiving care within the PHC is needed and it is possible as long as space can be created and the qualified personnel are made available to the people living with HIV and AIDS. Spiritual care as integral to holistic patient care in Zimbabwe is largely embraced in policies but not so much as such in the implementation of the policies. For health care providers, spiritual care training is often an exception and spirituality is not included in the curriculum of most formal education and training programmes. Hence, the main barriers to providing spiritual care are inadequate staffing and inadequate training of health care professions to detect patients' spiritual needs. Spiritually based interventions may help HIV positive people to live healthier lives. This may be of value to many as they deal with issues of spiritual pain, spiritual needs and their quest for healing. The spiritual care, which emerged in this research journey is about meeting the spiritual needs of people living with HIV and AIDS²¹¹. Spiritual care moves in the context of the person's expressed desires for relationship with God. The agenda is clearly set by the client.

On the other hand, traditionally secular counseling has steered away from incorporating matters of faith and spirituality into the psychodynamic setting and too often, this is considered the role and domain of clergy and traditional healers. Psychological models of counseling are based mainly on the medical model of curative approach. For many people, it is their spirituality that helps them cope with illness, trauma, loss and death. But for some reasons spirituality within the quest for healing has been consistently overlooked within the primary health care delivery system. However, this research has shown that spirituality as a hidden treasure within the people living with HIV and AIDS can be a vital resource towards their spiritual healing process. Human dignity is uplifted through deep respect for the uniqueness of each individual's spirituality. Cousins (1979:78-82) points out, "Death and dying are not the ultimate tragedies of life. The ultimate tragedies of life are depersonalization separated from the spiritual nourishment." Therefore, the spiritual care of people living with HIV and AIDS can be viewed not as an option but a necessity within the holistic approach to the care of people living with HIV and AIDS.

²¹¹ Silverman, D.J. (2000:23)

Patient's knowledge has little room in the scientifically, tested and proven body of knowledge. The present research journey conditions an attempt to emphasize the patient as a knower. I therefore distance myself from the biomedical approach to the care of people living with HIV and AIDS which assumes that, patients do not know and have to get the knowledge from outside. The position of the thesis is that, no one is completely without knowledge but rather, people may know different things depending on their social positioning and circumstances. There is also a two-way exchange of knowledge and information between those that were traditionally regarded as 'knowers' and those that had to be given the knowledge.²¹² The study agrees with what Shorter (1985) once observed about the Africans, Shorter (1985:3) says "it is not illness that are healed but people". To put it differently, it is not the physical manifestation of the disease (which is but a symptom) that has to be healed, but the broken relationships among people, the environment and God (which is the real illness.) Then we can talk of spiritual health or wellness when the person experiences wholeness within the self, with other human beings and living entities and transcendence with God. It is further demonstrated through such acts that show love, hope, humility, trust and forgiveness towards others.

The ability to address spiritual issues is no longer a matter of choice for the primary health care delivery system in Zimbabwe but rather, it is fundamental to providing holistic quality care to the people living with HIV and AIDS. The inability of care-givers to distinguish spiritual problems from psycho-social ones leads to inappropriate interventions. Hence, this may imply that the needs of these patients will not be met. I concur with Gerkin's (1997:91) question, "Are the structures that surround the lives of those under our care providing the spiritual support that people need in order for their lives to flourish?" But clinicians are not trained to treat spiritual needs of their patients and this is where the pastoral therapists can make a tremendous contribution. As clinical members of holistic health care team clinical pastoral caregivers as spiritual caregivers can play a vital role in journeying with people living with HIV and AIDS who are experiencing spiritual pain and are in need of spiritual healing. Clinical pastoral caregivers have the cosmology of all of life and a deep understanding of the interrelatedness of everything. Hence, they become the bridge between the patient and treatment which makes

²¹²Woolger (1983:244).

clinical pastoral caregivers not an option but a necessity within the holistic approach to care. The spiritual and pastoral approach to healing (1.2) explored in this research can be used by the pastoral caregivers as they do spiritual care with people living with HIV and AIDS. This type of care is described by Freedman and Combs (1996:1-2) as which,

Leads us to think about people's lives as stories and to work with them to experience their life stories in ways that are meaningful and fulfilling the metaphor that we use influence what we look, listen and feel.

Hence this new understanding of spiritual care leads us to think differently about those coming to us for care and about our roles as spiritual caregivers.

5.7 Conclusion

The chapter focused on the re-authoring of alternative stories of the participants based on the unique outcome that God can heal them, which was identified in Chapter Four. Re-authoring conversation maps were used to assist the participants create their new emerging stories. To help the participants “hold on” to the emerging stories, it was necessary to thicken the developing alternative stories using re-memembering conversations and outside witnesses. To expand the re-authoring of these preferred stories outside the group meetings, rituals and celebrations were done. However, it is important to note that re-authoring of the preferred stories does not only occur in therapy as we are all constantly writing and re-authoring the stories that shape our lives. Re-authoring conversations seek to create the possibilities for the generation of the alternative, preferred stories of identity. Once these have been co-created then the person concerned will have a foundation to continue to build on the belief and create meanings around this new story even outside therapy. In support of this, Muller, Deventer and Human (2001:9) state, “Therefore, narrative research doesn’t end with a conclusion, but with an open ending which hopefully would stimulate a new story and new research.” Triple (1984:1) pointed out that “even sad stories are able to generate new beginnings.” My task was to help the participants to become co-creators in the development of their own preferred stories of hope and their new identities. In the next chapter I adopt a reflexive position by looking back on the research journey as a whole and

also reflecting on some of the possible implications and suggestions for practical theology and pastoral care in terms of caring for people living with HIV and AIDS.

CHAPTER SIX

FOLDING BACK: REFLECTIONS ON THE RESEARCH JOURNEY

6.0 Introduction

The purpose of this chapter is to reflect on the research journey and its effects on me as the researcher as well as on the research participants. New questions are posed and challenges experienced during the research process are discussed as the reflection is done. Although reflection (1.12.1.3.11.9) on the research journey was done throughout the study as the journey progressed, the purpose of this chapter is therefore to emphasis the importance of reflection as an important learning activity and as a continuation of the research. The practice of reflection leads to empowerment of all the stake holders as it opens up space for the sharing of knowledges, for evaluative listening of various understanding of different stories and for constructive comments to be made on those understandings which are found useful and relevant²¹³. It is through the experiences of reflecting on our experiences that we make meaning of the experiences. Reflection is a particularly necessary process in this research journey as a post-modern/social constructionist ethic in which the researcher/therapist and the participants function. The ethical positives on which this reflection is based values openness, transparency, de-centering of the researcher/therapy, subjective-integrity, honesty and the deconstruction of any power relations that might exist. In addition, Freedman and Combs (1996:169) states that,

²¹³Tomm (1988:54)

Reflection can be viewed as a tool which the researcher/therapist and the participants use to interact and evaluate their experiences. It invites people to reflect on their own emerging stories and also on others' emerging stories so that they may continue telling and retell their stories

In this regard, research and therapy in this research were not viewed as two separate entities and they were used interchangeably. The idea was to think and do the research/therapy differently with a deliberate intention to move away from the old paradigm where, the researcher/therapist is indoctrinated to do research/therapy in a diagnostic, anthologizing, analytic and problem driven enterprise²¹⁴. The research journey was informed by the philosophical stance of postmodern, contextual, feminist and participatory theologies, postmodern and social construction epistemologies and was based on a participatory action research through the therapeutic lens of narrative enquiry. Hence, the reflection was done according to how the ideas from these theologies and epistemologies influenced the research journey in the quest to find spiritual healing from the spiritual pain experienced by people living with HIV and AIDS. The study was conducted with seven research participants who are HIV positive and receiving care at the Gweru Provincial Hospital in Gweru Zimbabwe. The study was done at the hospital with the aim of exploring how the spiritual needs of people living with HIV and AIDS could be addressed within the primary health care delivery system in Zimbabwe as part of the holistic approach to their care. With this in mind, it became imperative to create a therapeutic space within the hospital for the research/therapy to take place.

6.1 Reflecting on the therapeutic space

As the organizer of the therapeutic group meetings, I wanted to facilitate the creation of an atmosphere of curiosity, openness and respect where mutual care and “caring solidarity” made its presence and was felt²¹⁵. The interpersonal care and ethics which was negotiated by all the participants was reflective of Walker’s (1998:7) idea of an “expressive-collaborative” model. I discovered that it was the hope that the group meetings would bring people together in collaboration and would open opportunity for alternative spiritual practices for growth that kept

²¹⁴ Sekaran (1992:4)

²¹⁵ Sevenhuijsen (1998:147)

the group going. In the end, it became clear that the group was indeed a ‘community of concern’²¹⁶. Through the group as a community of care, there was a breaking of the discourse of silence about HIV and AIDS. I felt that the mutual caring and connectedness in this group facilitated this kind of sharing and even the public disclosure of participants’ HIV status to other people outside the group. It could be said that I was guiding the conversations more than the participants but at the same time I was ‘led by’ and learning from their experiences²¹⁷. I created a ritual space in the group because this was the first time for all the participants to share their stories publicly. This was very effective as it enabled me to listen to participants’ stories and not to let their voices be marginalized by my voice as a researcher. Below is Mai Chipso’s comment about the ritual place.

What has happened to me by being in this group is amazing. For the first time I was able to share with the others my story and what my life has been like since I tested HIV positive. I have been very lonely in my journey and I had no direction. I didn’t know which way to turn to until I became a part of this group. Now things are different. I have also realized that we cannot change other people but we can change and as we make changes in our lives people respond to those changes. I really appreciate what is happening in our lives through this group. I always look forward to our meetings because I come to share with others who are like me and I am given space to talk without being accused or misunderstood and that is very helpful to me. I can cry, laugh or talk freely here.

Looking back at the research journey, it is evident that people living with HIV and AIDS are willing and able to talk about their experiences. They do not talk about them because they lack the opportunity and the forum to do so. What I discovered is that the group setting provided the participants as people living with HIV and AIDS multiple opportunities to allow them to become visible and talk themselves into existence²¹⁸. The way the stories were told was very powerful to me. I was profusely affected by the stories and sometimes the stories were overwhelming and the sadness of the stories touched me and I could not hold back my tears. There were times we cried

²¹⁶ Freedman and Combs (1999:386), Winslade and Mark (1999:100-101).

²¹⁷ Anderson and Goolishian (1992:32-33)

²¹⁸ Davies (1993:21)

together as sisters and brothers holding each other's hand. I have to admit that, I have seldom experienced something that has moved me as deeply as the stories of the participants in this study.

When reflecting on the research journey, all the participants voiced their appreciation of the group process and the solidarity and oneness we experienced in our meetings. I discovered that all the participants engaged stronger, with a more robust sense of self as they became more aware of themselves. The luminal space thrust the participants into a reconsideration of established understanding of life and identity. Mukoma K.K described the meaning he has made of his experiences as,

So in some ways I value my life experiences because I think it's made me a lot deeper, more sensitive and more reflective and introspective, perhaps a person with more intensity, definitely a better person in many ways. And have stopped asking God all those questions.

Mukoma K.K spoke of having been through the fire which resulted in him feeling invincible and more competent to deal with relationships. Mother thought she could use her experiences to help other women. The katharsis evidenced in their time of rebirth led the participants to new perspectives on their lives, history and identity to think beyond what they would normally think. To make new meaning of their experiences not previously understood and to initiate steps into territory not previously contemplated²¹⁹. Mukoma T.J spoke about the intrinsic safety he experienced from the beginning and commented after one of the sessions, "thank you Farirai for your wonderful facilitation." Mai Paida agreed that the group was very safe and added that what worked for her was to be in an environment that was caring and trusting which enabled her to share at a very deep level without reservations. Mai Chipso said,

I found the space here very comfortable, safe and trustworthy to share. I also like the number of people in the group seven. We are not too many we can communicate and connect easily even outside the group meetings we send each other messages on the phone. The loneliness now is gone. I now have friends and family who love me unconditionally.

²¹⁹ White (2002a:16)

The above comments highlight the importance of facilitation and negotiation, power sharing, care, trust, confidentiality and relationship between people and their environment. From the beginning to the end the participants engaged in respectful and collaborative practices that contributed to ethical participation, consciousness and ethical ways of being.

6.2 Reflecting on the theological and theoretical framework of the research

The theological and theoretical framework I chose for this research has been thoroughly explained in Chapter One. Working within the various philosophical paradigms chosen for this study, I felt comfortable and ethical by learning from the participants. The research was therefore less concerned with “systematic and organized efforts to investigate a specific problem that needs a solution.”²²⁰ This framework made the research to be a collaborative activity by means of which a given phenomenon or reality was shared and experienced in a manner that embraced subjective-integrity, rather than “a structured inquiry that utilizes acceptance of scientific methodology to solve problems.”²²¹

6.2.1 Reflecting on contextual theology to practical theology

Contextual theology guided my way of doing research/therapy, so the participants’ local contexts and their lived experiences of being HIV positive informed my pastoral involvement with the participants. Starting with local meanings of God in therapy/research means that the contextual theology we engaged in was theology from below²²². In this way the dialectic relationship between theory and praxis was turned upside down. I also realized that working with people’s local meanings of spirituality and with their personal relationships to God implied a contextual approach. This resonated well with the participatory action research which requires a connective understanding that is more than mere empathy. This implied ‘connecting’ with the participants at their level in their context. For instance, when the participants spoke about linking their God, ancestors, spirits and witches in an intertwined way which they understood as the spiritual root cause of HIV and AIDS my philosophical stance helped me to accept their perspectives on their knowledges. When the participants spoke of visiting the traditional healers and the faith healers I

²²⁰Sekaran(1992:4).

²²¹Gronnell (1993:4)

²²² Bosch (1991:423)

genuinely listened and realized their desperation in their quest to find healing. When they spoke about God being the ultimate healer, I responded with genuine curiosity to such a unique outcome and endeavored to facilitate the re-authoring of the new stories which started to emerge.

As the participants articulated their need for spiritual healing, I started reflection on the issue of social transformation as an important way of taking action in contextual theology²²³. Transformation goes hand in hand with action that leads to change and as pastoral therapists who are confronted with patients' physical, emotional, psychological and spiritual pain as a result of illness, their isolation and marginalization as a result of the medical system, society and the church's way of handling illness, the moment when we are so intensely touched by people's distress becomes the 'moment of insertion'²²⁴. This provoked me as a pastoral caregiver to take a definite ethical stance in favor of the people living with HIV and AIDS against the disempowerment and isolation discourses and practices. Hence, social transformation is aimed at empowering the people living with HIV and AIDS to believe in their abilities and to become active participants and role players in the process of transforming the healthcare delivery system in Zimbabwe. Cochrane, De Gruchy and Peterson (1991:91) comment that. "those who experience themselves as 'nothing' in their society discover a new identity as 'some one' to one self and to others who become a human subject- an active agent in history who may participate in deciding on constructing a world to live in and not others constructing for others. In this regard, the participants continuously expressed their desire to have spiritual care incorporated into the primary health care delivery system. I realized that this was a moment of re-awakening for them which could lead to transformation of healthcare services for people living with HIV and AIDS in Zimbabwe. I realized this understanding of social transformation resonated well with feminist ideas on justice for all.

6.2.2 Reflecting on feminist theology

The understanding in feminist theology is about justice for all as explained by Isherwood and McEwan (1993:79)

²²³ Ackermann 1991:108, Cochrane, De Gruchy and Peterson (1991:2)

²²⁴ Cochrane, De Gruchy and Peterson (1991:170)

As we find space for ourselves for that which offers integrity and justice, so we change the concrete reality of others. In finding our justice, our liberation we hold it out to others namely the oppressors and the oppressive structures, In naming our experiences we pose questions, the answering of which will radically change society.

In line with the above quote, the feminist conviction that the personal is political helped me realize that the participants' need for spiritual care to be part of the holistic approach to their care may lead to a revolution within the primary health care delivery system, that will enable people to move towards greater freedom and wholeness, while challenging the structures that impede this. I discovered that reconstructing spiritual care with the participants in this research journey implied engendering the responsibility for shaping their own lives in the trust of God which would empower them to become agents in creating a more just health care system in Zimbabwe which also acknowledges the spiritual dimension of being human. The slogan in feminist theology "the personal is political," expresses the interconnectedness of everything and this acquired spiritual care would have an impact in the wider community to which the participants are connected.

Being praxis oriented, a feminist theology values people's experience including their spiritual experiences, knowing that all theology is in a sense experiential and experimental²²⁵. Feminist theology recognizes as one of its tenets that, our coming of old dichotomies and the listening in an understanding of pluralistic society gives speech to the speechless, which empowers the powerless and which lets outsider participate²²⁶. In this regard, I realized that my conversations with participants about spiritual issues became a two-way traffic where despite my training in psychology and theology, I could learn from clients about their skills to be faithful to what they believed God to be their healer, while living their lives amongst the challenges of living daily with the HIV.

6.2.3 Reflecting on Postmodern Theology

When I decided to use postmodern theology in this study, the challenge I had was, how was I going to apply a postmodernist approach to my own life and the lives of the research

²²⁵ Ackermann (1991:107)

²²⁶ Isherwood and McEwan (1993:91)

participants? How was I going to work with a participant who didn't believe in God? The main difficulty I faced was that Christian Faith means believing in the 'truth', that is the path and life whereas the postmodernist approach refuses to apply the criterion of 'trueness/falsehood' to any descriptions of the world? Is it possible to acknowledge the plurality of possible descriptions of reality and at the same time to be true to myself and my own inner subjective experience of truth? As the conversations with the participants went on, I also asked myself, is Christianity itself a dominant discourse or is it a marginalized one? However, what I appreciated in using this paradigm was that, postmodern theology reminded me that there are as many different solutions to life's dilemmas as there are believers and such differences are worthy celebrating because they allow us to continuously expand our understanding of how it is possible to live in many different circumstances and still be true to my Christian story. I also realized that postmodern theology allows pastoral caregivers to follow Jesus' example who criticized the dominant discourses of his time including the religious ones.

I found the following reflection by Alexander and Cook (2008:1) helpful when she observed that postmodernism doesn't deny the existence of things as such, but states that in any description that we make of things we do by means of language and language is a product of the cultural and historical context. Therefore, social prescriptions impact the construction and meaning making of the experiences of spirituality to the same extent as they impact the construction of experiences of illnesses. In this regard what I discovered was that, narrative approach to research gave me the tools to accurately know myself and what I know. It also gave me the tools to listen to the participants' stories without being skeptical or making judgments no matter how nonsensical or mythical I would have thought about what was said. It also gave me tools to guide the questions I asked the participants and I expressed genuine curiosity and respect.

In further reflecting on postmodern theology in this work, Alexander and Cook (2008:43) helped me to realize that Jesus protested against the dominant presumptions of the Pharisees in defining the experiences of spirituality. He voiced alternative ideas and practices of freedom, belonging, equality, respect and sincerity. He called for the reinstatement of subjugated knowledges which in the case of Jesus was the knowledge of personal, liberating, compassionate and accepting

God. I also recalled that the Jesus I read in the gospels, constantly challenged authority, questioned interpretations that authoritative experts considered to be sacred and constantly honored and acknowledged the poor, the marginalized and the powerless²²⁷. In this paradigm, I became more convinced through this research that a Christian person's duty in this life, is to deconstruct or question existing cultural and religious practices. I also became more convinced that a person's faith is about relationship with God and not about following a particular doctrine or denomination.

I also realized that God is the only witness to some aspects of my life. In terms of narrative therapy I would say, God is the paramount member of the 'club of life'. The relational identity of the person is co-constructed primarily in this relationship. I became convinced that the person's story is always co-constructed/authored in this relationship with God and never authored solely by the person themselves. As I reflected upon this approach to therapy, I realized that narrative therapy is always a 'tripartite' approach and three parties are always present in some way, the person in the centre, the therapist and the 'supportive other' no matter what form they may take. My role in this regard was to find out from the participant what God was up to and try to be part of that. In this research, according to the participants, God was up to healing them from spiritual pain. I became part of the healing process which just began in this research journey.

6.2.4 Reflecting on Social construction

Working from a social construction perspective which I viewed as a page from post modernism, I discovered that the uniqueness of the participants and the uniqueness of the situation determined, moment by moment how to proceed with the conversations and collaborative interactions focused, without judgment on the participant's definition of the problem and solution. Hence, reality went where the conversation went²²⁸ and as knowledges are created through social interaction, language is the tool for explaining reality and making meaning²²⁹. It was important to use Shona during our conversations. Mukoma T. J shared how language used in the research journey helped him to openly express himself in his own language without fear of

²²⁷Alexander and (2008:69)

²²⁸ Boyd (1996:219)

²²⁹ Drewery and Winslade (1997:34), Freedman and Combs (1997:23)

being misunderstood. He gave an example that if we were to use English in the study he was not going to join the group. He was so grateful that in our initial session we agreed to use Shona throughout the study although I had to translate everything into English later. All the other participants echoed the same sentiments. They were happy that they were able to talk about God in their own language as they understood Him.

As I continued working within the social constructionist paradigm, it became clear to me that the intertwined nature of our construction of our own identity and the self is viewed, not as a core or essential entity but as something that is constituted in relationship with other people and with God. Gergen (1991:139) describes identity in the following way

In the postmodern world there is no individual essence to which one remains true or committed. One's identity is continuously emergent, re-formed and redirected as one moves through the sea of ever changing relationships. In the case of "who am I?" it is a teeming world of provisional possibilities."

The social constructionist idea of identity being constructed within relationships opened space to explore the participant's relationship with God as a way to understand his/her identity construction. Inviting God-talk and how God can heal the participants' spiritual pain introduced alternative ways of looking at self. I found out that it was often the participants' faith-talk that helped to give them a sense of who there are in God. Although people use language to construct their world and themselves, I realized on the other hand that language inadequately gives meaning to people's experiences of spirituality.

6.2.5 Reflecting on participatory action research

Participatory action research has taught me that a research journey can never be planned ahead in terms of fixed aims²³⁰. It was useful for me to have a map of the research journey in mind as it offered me a loose framework to guide the beginning steps of the journey but in no way prepared me for the unexpected twists and turns as I navigated the lived experiences of the 'territory' of participatory action research. An example of an unexpected turn where the map was not the

²³⁰ Derrain and Lincoln (1994:12)

territory is the 'story' of time allocated for field work. I had initially planned for the fieldwork to take three months but it went on for almost seven months. I had initially planned to have individual and group meetings with the participants but it turned out that the participants preferred more group meetings than individual sessions as they pointed out to me that they no longer had anything to hide from each other. Understanding that the map is not the territory highlights the need for flexibility and participatory consciousness.

The need for flexibility also applied to the idea of doing research with co-researchers. The participants became equally involved in the research journey as I was. I discovered that this idea of ownership of the research made them feel respected, valued and honored. This helped them to realize that they were benefitting from the research process and their presence at group meetings was important. The co-researchers tried by all means to attend the meetings regularly and if a participant was not coming they tried by all means to send word. I also observed that the idea of equal participation contributed so much to the outcome of the study as they all shared their experiences without reservations. Below is the reflection on doing participatory action research through the therapeutic lens of narrative enquiry.

6.2.5.1 Reflecting on the narrative approach to research

The research according to the narrative approach, argued that people live the stories they tell and tell the stories they live and these lives are constructed through society and self. The research suggested that these stories, since they can be constructed, hence they can also be deconstructed and re-constructed. This implies the exploration of neglected and 'unstoried' versions of life experiences. By cultivating those neglected and 'unstoried' events, new and preferred ways of living are constantly developed and in the process preferred outcomes become a possibility. Through developing conversations it showed that there are multiple voices and multiple stories and as a result of the unimaginably indescribable pain experienced by people living with HIV and AIDS, the participants in the group were confined to the descriptions about themselves and their stories. In using the narrative approach, the emphasis was on people living with HIV and AIDS as the experts of their lives. This was about giving them power, which was revealed by talking to them respectfully with love and inclusion.

I found out that the narrative approach fits very well with contextual, postmodern, participatory and feminist theologies by centralizing participants' stories and by not reducing them to being passive recipients of expert professionals. The story telling of the participants in their own voices and according to their own experiences centralizes their own contexts and does not confine them to external theoretical classification systems. Narrative approach which centralizes participants' own contexts through their story telling is therefore a meaningful way of giving expression to a contextual, postmodern, participatory and feminist theology. This is supported by Kotze and Kotze (2002:30) who state,

The more we participate in such a way that the voices of all especially those who have been preciously silenced, can be heard, the more we can research and co-construct in an ethical manner an ethical, just and ecologically sound world to live.

In this research, narrative therapy from a postmodern, contextual, participatory and feminist theological perspective emerged as a pastoral approach which can be used in the process of co-constructing spiritual care with people living with HIV and AIDS within the primary health care delivery system in Zimbabwe as long as space can be created. Engaging in the narrative practices, proved to me its effectiveness and also its seemingly yet deceptive simplicity. Balancing on the boundaries of knowing and not knowing, connecting and detachment, reflecting on the therapeutic process, while busy with the research and therapy, to decide which thoughts are generated from our interaction and which ones are from my 'unconscious' assumptions as well as centralizing the participants' greatest concern at the present moment and so on, will always be a challenge and an art that may only evolve with experience.

Narrative approach does invite the researcher to consult the participants. Although I initially opened space for the group to ask me questions about myself as we journeyed, I could have checked with the group if they wanted further disclosure. Reinhartz (1992:34) cautions about reformulating the researcher's role in a way that maximizes engagement of the self, but also increases the researcher's vulnerability to criticism, both for what is revealed and for the very act of self-disclosure. As I reflect on my lived experience in this research journey, I have no doubt that researcher discretion and discernment are key factors as well as aspects such as knowledge of the participants, the timing of researcher self disclosure and the degree of disclosure are of the

utmost importance. These were influential factors in my role as researcher/therapist engaging in a narrative approach to participatory action research.

On the other hand, I found the group to be very generous of themselves in their sharing and witnessing. In contrast, I thought I was perhaps a ‘little, stingy’ in the sharing of resources and information, in my efforts to ‘care with’ rather than to care for the participants. In future I think I would be more flexible, more discerning as each group would have differing needs, desires and responses. A narrative approach to participatory action research, prefers egalitarianism rather than the scientific ethic of detachment and role differentiation between researcher and subject. In the area of self disclosure and information sharing, I erred on the side of scientific caution. Ironically, it was a decision made from a narrative perspective differences between ‘researched’ and ‘researcher’ and not working to offer information from a hierarchical, expert position. I have come to realize that ethical participation consciousness requires constant discernment. In future therapeutic and witnessing journeys there will always be a need to discern how, when and what constitutes ethical participation.

It is a requirement of participatory action research that the research should provide the participants with “some kind of improvement and change²³¹”. Throughout the whole research process, I was constantly concerned about ensuring that participants would benefit from taking part in these conversations. I asked the group whether the narrative and participatory approaches to care have been a mutually empowering experience for them. And this is what they said.

Mukoma K.K.

I have never been part of a research group before but what I have heard or seen in some places is that, the researchers will be having these papers with questions, which they will ask you to complete. The papers are usually written in English and you don't know what to write there. But here it has been different. We were all involved from day one. We sat down and we had conversations in Shona. I really liked that. I felt like I was part of the whole process because we spoke in our language and we were heard in our language.

²³¹Mc Taggart (1997:27).

Mother

I was surprised right from the beginning the way you did things in this research. We became part of the research process as co-researchers and we learnt that we were the experts of our lives. At first I didn't understand that but with time I learnt that this work was about us and for our benefit. We were the ones who were benefitting from the research. We spoke and were not judged or condemned. I learnt through the others things I have never known about me. I became empowered to share my story. I realized that I had fellow companions on this journey and I didn't need to carry the burden any longer by myself. A lot of good has happened to me by being part of this research journey.

At the outset of the research journey, I had only been aware of researcher stress as pertaining to the academic process of data collecting, recording and writing. I had no idea that researcher stress would emanate from listening to the stories of the participants. It was the ethic of commitment which enabled me to keep going and to stay focused. It was not only the pain and suffering which moved me. I was also profoundly touched and inspired by the resilience and courage evidenced in the narratives of the participants.

6.4 Reflecting on power sharing

Doing participatory action research, I was challenged by a commitment to confront my power position as the researcher fulfilling an academic role. McTaggart (1997:3) claims that in order to challenge this academic role in pursuit of equal participation, “considerable energy must be directed at ensuring reciprocity and symmetry or relations in the participatory action group and maintain community control of the project.” I shared this commitment towards participation by confronting the subtlety of power²³². I was therefore, mindful of Foucault's (1980:96-98) idea that all power is relational. The use of a narrative approach ‘not-knowing’²³³ position of the therapist/researcher and my respect for the participants' knowledges was encouraging and

²³²Mc Taggart (1997:33)

²³³ Anderson and Goolishian (1992:28, Freedman and Combs (1996:4-45

empowering. In agreement with Anderson (1997:107) I purposely wanted to be open, genuine, appreciative, respectful, inviting and curious in this therapeutic relationship that was mutual, collaborative, cooperative and egalitarian because I valued it. An egalitarian relationship in a therapeutic situation was a bit strange to the participants at first as they expected me to be the expert and supply all the answers to their suffering and even to tell them what God would think of their decisions whether they were making good decisions or not. As a pastoral caregiver, I made it clear to the participants that I was not interested in attempting to convert them within therapy²³⁴. My commitment was to do spiritual care as participatory ethical care with them as people in need of care and not for them²³⁵.

Traditionally, it is a common practice of psychologists and psychiatrists to assess clients/patients according to a classifying system, the DSM-iv- Diagnostic and Statistical Manual Disorders that subjugates them to normalizing truths²³⁶. This system operates as a labeling technique of power that has a totalizing and pathologizing effect on the person. A non pathologizing approach, derived from collaboration/ constructive therapies is according to Boyd (1996:216) one of the central tenets of pastoral theology. This was the power-sharing position which was maintained throughout the research.

6.5 Reflecting on the human text and written text

Both participatory action research and narrative enquiry highlight collaboration, participatory consciousness and joint decision making throughout the research process. I had hoped that the participants would work with me, not only as co-researchers but also as co-authors of a reflexive text. Moson (2002:177) writes of jointly reflecting on the research as it becomes a written text, arguing reflexively and multi vocally. Mouton (2001:151) cites “ownership of findings” as strength of participatory action research. When I completed the first draft of a chapter, I would give it to the participants asking for their comments. I would say,

I need to ask you to please read this chapter very carefully. I have used your comments, transcripts, feedback and I have done a lot of cutting and pasting. If you read anything

²³⁴ Drewery and McKenzie (1999:139)

²³⁵ Kotze and Kotze (2001:7).

²³⁶ Freedman and Combs (1996:21)

and feel you have been quoted wrongly or out of context or have been juxtaposed in a way which makes you uneasy or feel I have left anything out or if you want to add anything please let me know. This is 'our document' and we are co-authoring it. All comments are welcome.

I did not receive any critical responses, amendments or suggestions from the co-researchers. I presented the opportunity for feedback on the written text. It is possible that I did not receive any critical feedback or corrections because the group felt that I had presented their voices in an authentic and respectful manner. I now have clearer insight that when it comes to presenting the research report, the text that is produced from the interpretations of the text generated in the conversations with the research participants, is the researcher's story of their lives. Despite my desire to share power with the research participants in constructing new meanings, this dissertation is thus my story of the narratives of the participants and is influenced by various discursive positions. On receiving and reading the first draft of Chapter three, Mukoma Tippy said something which confirmed this insight.

I feel honored to be part of this research project. I am proud to be 'Mukoma Tippy'. I don't regret anything I shared. I feel I spoke my heart, my mind and my spirit out and nothing I said was misunderstood or misinterpreted by you. You presented the stories of my pain and suffering in a sensitive, dignified and caring way.

I came to the realization that whilst as the researcher I was constructing the written text, the participants continued to live the stories of their lives and continued to talk with one another and not to one another. Hudson (2000:97) a qualitative researcher positioned in a narrative approach made a similar discovery. I discovered that another research journey occurred as the research participants and the researcher entered into each other's lives, building relationships and fostering communality. This second part of the research journey extended beyond our research group of eight people. As we entered into each other's lives, we shared more about our families, communities and relationships, building a large network of people, interlinked through us.

6.5 Reflecting on the re-authoring of alternative stories

The reflection on re-authoring conversations was done together with the idea of witnessing experiences because I discovered that the re-authoring of new-stories of hope occurred in the presence of witnesses, who influenced the re-construction of the alternative stories. I connected this thought to how Weingarten (2003:197) describes listening to others telling their stories helps the speaker to “drop down into himself”

Listening as a foundational skill for intentional compassionate witnessing requires a willingness to be touched. For that to happen we have to open our hearts as well as our ears. This kind of listening is non judgmental and accepting. It gives space and time for the other person to drop down into herself to see what is there that wants to be brought forth. It creates an opportunity for the speaker to plunge into confusion and uncertainty, knowing that she will be accompanied by steady companions who will listen to her story without taking it over.

This was confirmed by Mainini Shupi as she stated, “what has been highlighted for me is the fact that we are constantly growing and being shaped and our perspectives changing.”

When people are witnessed by others or when they witness themselves, re-membering takes place as parts that have been scattered, shattered and forgotten are brought back together²³⁷. Re-membering restored possibilities, invited hope and provided opportunities for engagement with others in the generation of rich descriptions of the stories of their identity²³⁸. The validation of self narratives depended on the affirmation of others. For instance, when Mai Chipo reconnected with the belief that only God can heal through this witnessing journey, spiritual pain was no longer fore-grounded and the options of spiritual healing became available to her. A migration of identity and meaning took place as Mai Chipo re-membered parts of her which had been obscured by the presence of spiritual pain. Landscape of identity and meaning was interwoven with landscape of action as Mai Chipo stated, “where I see myself in this journey is near the finishing line. And I will not go back there again.” In re-membering, Mai Chipo was also able to privilege knowledges and skills of living that had been forgotten in the presence of the problem saturated story of indescribable pain and suffering. During the course of the six months we were

²³⁷ Weingarten (2003:196)

²³⁸ White (1997:62)

together, the participants became a community and where there had been isolation and loneliness, a sense of solidarity, a common bond made its presence felt. The community became an audience to the lives which were previously marginalized and self reflexive consciousness contributed to achieve awareness, compassionate witnessing, witnessing self and witnessing each other.

As a researcher, it had been of utmost importance to me that the group of participants was to include both genders. I thought it might provide some insights for both participants to hear men's and women's stories so as to see both as vulnerable to spiritual pain. The women in the group were profoundly moved as they listened to the men's stories. To be moved in the witnessing experiences of life in the sense that, this transporting can be defined as a kathartic experience²³⁹. For the members of the witnessing team to be together moved in this way evoked 'communities' a unique sense of being present with each other. The participants reported the effects of listening to the narratives from both genders.

Mainini Shupi

I felt enormously privileged to listen to what Mukoma K.K said. I have never heard a man open up like that. I haven't had an opportunity to listen to a man talking about his experience in the manner you did. This is the kind of thing you read about. I felt moved and touched by your life experiences. It has made me realize that there are times when men are also vulnerable just like us women.

Mother

Although I have never been to therapy at all, I have never listened to men who can talk openly about their experiences of living with the virus. This has made me think about my late husband. My husband never spoke about how he felt about being HIV positive and sometimes I think that maybe that silence, keeping it all to himself contributed to his death. I just wish if more therapeutic groups like this could be there for more people to be

²³⁹ White (2000:76)

helped to talk about their experiences. Also now I have an idea of how my husband felt when I used to accuse him of giving me HIV.

Mukoma Tippy

I have been to some support groups before but I have never listened to women talking openly about almost everything like Mai Chipo did here. When she spoke about how she hates using condoms when they meet on the mat with the husband, I had an idea of how my wife feels when I wear a condom during sex. I thought she hated me that's why she didn't want us to use the condom. Now I realize she is not the only one. At least I have some understanding on this matter. Thank you for being so open and expressive about your experiences.

Making the movement from “terrible silence” to “transforming hope” means not only giving voice to women, but to men too²⁴⁰. This shared sentiment ties in with what Weingarten (2000:402) describes, “hope is something we do with others.” I discovered that, hope too, is important and its effects on the body, mind and spirit are too significant to be left to individuals alone. Hope must be the responsibility of the community. I discovered in this research journey that, witnessing provides hope when it is an inclusive process, which accounts for context and moves beyond silencing or debate to make room for a richer understanding of meaning. The concept of compassionate witnessing, with its accompanying vulnerability and hope became a lived reality in this research group, which met at Gweru Provincial Hospital in Zimbabwe. The compassion, vulnerability and hope were evidenced in two ways, within the group and within the individual.

As relationships developed within the group, Myerhoft's (1982:11) notion of ‘membered lives’ came to mind. The notion of re-membering suggests possibilities for engagement in a revision of relationships. White (1997:23) suggests that, “through re-membering practices, persons can suspend or elevate, revoke or privilege and downgrade or upgrade specific memberships of their lives.” Of particular significance to this research journey are these words of White (2000:124)

²⁴⁰Graham (1999:185)

It is in this way, through re-membering practices that persons can have more to say about whose voices are to be recognized on matters of their identity. In these acts a person experiences the stories of their lives linked to the stories of the lives of others around particular themes and shared values and commitments. The sense of being joined in this way and of experiencing one's life more richly described, contributes to new possibilities for action in the world. It also renders persons less vulnerable to experiences of being alone in the face of adversity.

The second way in which compassionate witnessing was evidenced in the group was in relation with the self. I observed that self witnessing requires a self reflexive consciousness. Weingarten (2003:27) explains self witnessing and its correlation with self awareness and meaning making as;

All of us whichever role we are currently in can witness ourselves. We can become aware of what we see when witnessing ourselves as witnesses. We can become aware of what has happened to us witnessing ourselves as victims. And we can become aware of what we do to others witnessing ourselves as perpetrators more able to witness ourselves in each of these roles we will be better able to witness others in each of these roles as well

Awareness is a key element in developing the capacity for self-witnessing. As the participants witnessed others they also witnessed to self and found themselves in compassionate self-witnessing positions as they journeyed towards spiritual healing.

6.6 Reflecting on the journey metaphor

The metaphor of all of us together on a journey²⁴¹ added richness of meaning to our togetherness in the group by describing qualities such as a long term process of commitment, relationships, love, acceptance, exploring new territories, hope and so on. This resonates with what Mai Paidá said about the journey metaphor when she said,

It reminds me of people walking together going somewhere far away. These people are of different ages. Some are old some are young. Some are weak and some are strong. With time

²⁴¹ Morgan (2000:3)

some may get tired and others will help them carry their heavy load. This is us on this journey. We have all become one and we are there for each other. We are now like people on the same bus going somewhere. Some may arrive earlier than others and some later but we are together on this journey to healing.

The group members said that when they looked back at significant steps they took on the journey away from the problem saturated story to the alternative version of healing, it created hope in them. This was further enhanced by the rituals and celebrations which we had as a group. The group participants said that the use of externalized language was very effective in helping them to separate the problem from the person. As the spiritual pain no longer defined their identity, it opened up space for them to take action against the problem by identifying abilities, hopes, beliefs and competencies that could aid them on their journey to healing. Mukoma T.J commented,

To journey with other people has demonstrated God's love to me and I am filled with hope when I look back on my life and realize that I have made progress in the direction of spiritual healing.

Using this metaphor allows people to make a distinction between where they were and where they are now. Mainini Shupi described the journey as taking small baby steps one day at a time bubbling with the hope that one day we shall arrive.

6.7 Reflecting on spirituality and spiritual care

My research curiosity for this study stemmed from the recognition that healthcare needs to be holistic and person centred for the best outcome for people living with HIV and AIDS and to me, this created an expectation that spiritual care could also be incorporated into clinical practice. The wish of participants that their spiritual well-being be considered in their health care has added momentum to this expectation. As I journeyed with the participants on this research journey, from day one they brought God into the conversations, I started asking myself why spiritual care of people living with HIV and AIDS has not been provided within the healthcare system in Zimbabwe. I reflected on the spiritual support for people in situations such as the armed force and the police force where it is being provided by chaplains who are usually

ordained ministers of the Christian Faith. This brought hope to think that, if for some reasons, the spiritual needs of the police and the army are catered for, there could also be room to consider the need to provide spiritual care to patients as well.

I realized that the spiritual care which occurred in this research journey played an important role in giving sense and meaning to the participants' lives. The words of Louw (1994:61) that pastoral care gives patients an opportunity for growth, witnessing and deepening of faith applied to the spiritual care which took place in the research. From a contextual perspective, spiritual care with the participants strived to find new ways to involve the community and medical system so that their stories can be accommodated, centralized and respected within the discourse of incorporating spiritual care into the primary health care delivery system in Zimbabwe. I discovered that spiritual care in this research journey was done from the position of not caring for, but rather care with participants²⁴². This ethical perspective of doing spiritual care accentuates the importance of participation in the processes of pastoral practice. Spiritual care with patients, regarding them as participants in their own healing process, opens the door for social transformation that contextual theology advocates.

Health care professionals are entrusted with the holistic care of their clients. This means nurses and other healthcare providers care for the mind, body and spirit and spiritual care is a part of holistic care. People's spirituality impacts various aspects of personal, mental health and interpersonal behavior as reflected in the stories of the participants in this study. It has an impact on the satisfactions and the stresses that people experience and it impacts the problems they bring into therapy where these can be regarded as explicitly spiritual or not²⁴³. De Jongh van Arkel (2000:139) points out that, "although people come seeking personal help they do not merely want to reorganize their relationship to themselves and others, but also their relationship with God." However, in this research through spiritual care, the participants came to realize their need for a relationship with God as their healer.

6.7.1 Reflecting on conversations with God

²⁴²Kotze and Kotze (2001:7)(Kotze and Kotze 2002:18

²⁴³ Everts and Agee (1994:293)

From the outset of the research process, the participants brought God into the stories and conversations. In their stories and conversations reported in this study, God's voice resonated strongly. God was linked with the spiritual root cause of HIV and AIDS according to their perspectives. He was also linked to their spiritual pain where the why me questions were directed to Him and later through the processes of deconstruction and further conversations, the discourse shifted to God as the healer of their spiritual pain which became the base for re-constructing the alternative stories of spiritual healing. My role was to be a witness of participants' relationships with God and to find a way to invite God's voice into the therapeutic conversations. I took note of the words of Griffith and Griffith (2002:109) "person-God conversations like human conversations, need to become dialogical rather than monological if they are to provide the creativity needed to solve life problems." However in this research, I observed that when participants talked with one another about their personal relationship and conversations with God, a richer meaning was constructed in that conversation. I also realized that it was necessary for me to move from certainty to curiosity, to wonder and to be willing to be informed by the participants about their beliefs and experiences with God.

When the participants talked of questioning God about the meaning of their suffering, I realized the words of Gughes (1985:17) that true Christianity will always be critical, questioning and continuously developing in its understanding of God and His involvement in human life. I saw the participants' questioning of God's purpose for such deep pain and suffering as a form of resistance that could enable them to develop a closer relationship with God in the end. I am also thinking of Mother when she said,

I used to ask God why He allowed this disease to be on me. But in my questioning, I realized that I was having these conversations with God and He also started asking me questions which I had no answers. Through my questioning I have become closer to God and I now spend a lot of time reading His word. My spiritual life is growing daily and I like it a lot.

When the participants started to talk about God as the healer of the spiritual pain, it was a challenge 'to honor the in- determinacy of the relationship by believing that it holds numerous possibilities for movement and by conversing in a way that brings forward its many

possibilities²⁴⁴.” I was startled and in my internal dialogue I asked myself, “How is God going to do that?” However the participants’ remarks brought me joy and strengthened my passion for the work. When I asked them how God was going to heal them, they answered that it was up to Him because He knows the way. In other words, God was invited into conversations about what He was up to. The participants left it up to God to make the seeds grow and this gave me great joy after the sessions. I considered myself privileged and highly honored to participate with the participants in a small slice of their lives. I am grateful to the participants for giving me the opportunity to be involved with them in a process of caring with them as a constitutive process of my being.

Our journey together brought faith not only tears, but also many laughs and enjoyment. I have a deep respect for these participants for they allowed me to peep into their ‘spirits’ and see the pain and suffering which was embedded there in. Such trust humbled me, realizing my own inability and limitedness to supply the ‘right answers to their questionings. Being aware of the entrapment of knowing²⁴⁵ required me to embrace certain humility especially in the light of the potential of spiritual talk to both heal and harm²⁴⁶. A not-knowing approach required of me, a humble spirit that would be prepared to welcome the unexpected and the unpredictable. This, on the other hand contributed to the joy of being surprised when we discovered the unexpected, the unique outcome, that God is the healer that, led to the re-authoring of alternative stories. The participants taught me the importance of listening and observing attentively. They taught me humility and I will always be grateful to them for the trust they invested in me and to allow me to use their stories of indescribable and unimaginable pain for this research.

As I was keen to avoid other prescriptive and proscriptive constrains, I found myself caught in a tension which resulted in an ‘avoidance’ which I regretted later as I realized I had been restrained in opening up the conversational space for more God-talk. I missed opportunities to the construct, the effects of religious discourses on people living with HIV and AIDS especially when the participants voiced that they had not disclosed their HIV status to the church because of

²⁴⁴ Roth (1995:142)

²⁴⁵ Griffith (1995:125)

²⁴⁶ Griffith and Griffith (2002:9)

the fear of being rejected and stigmatized. Informal conversations whilst having tea or lunch could have led to rich discussions on such discourses.

6.8 My personal reflections

As an analogy, Moore (1992:21) refers to the Greek story of the Minotaur,

The bull headed flesh eating man who lived in the centre of the labyrinth. He was a threatening beast and yet his name was Asterion-Star. I often think of this paradox as I sit with someone with tears in her eyes, searching for a way to deal with the beast, this thing that stirs in the core of her being, but it is also the star of her innermost nature. We have to care for this suffering with extreme reverence so that in our fear and anger at the beast, we do not overlook the star.

This analogy helped me throughout the research journey to consider the participants as the stars, although I didn't like the havoc, the spiritual pain and suffering HIV and AIDS (Minotaur) has caused on their lives. Because of this, I became aware that I too was being changed as we journeyed together with the participants. I found myself transported to places and into territories of life and identity/meaning that I had never imagined and katharsis took place. White (1995:7) confirms,

Therapeutic interaction is a two way phenomenon. We get together with people for a period of time over a range of issues and all of our lives are changed for ever

White (1999:73-74) clarifies katharsis in its classical sense as,

People being moved in the sense of being transported to another place, where they could not have been otherwise as a result of witnessing a performance of life that is 'gripping' of them.

White is not referring to the contemporary psychological understanding of catharsis (retelling of the traumatic events with a view to "discharge and release" but which result in re-traumatisation) but to katharsis which is understood to be a response to 'witnessing powerful expressions of

life's drama²⁴⁷, and a way of making meaning out of our own responses. This understanding of katharsis invited me to be vigilant and reflexive throughout the research journey. I also observed that katharsis also took place in the participants. At the end of one individual session with Mukoma T.J he said, "Telling my story shows me how far I have come."

This journey with people living with HIV and AIDS has inspired me to spend more time trying to live in the narrative with a new commitment. Baart (2003:137) explains this narrative about care as follows,

A characteristic that they (pastoral therapists) have in common is that they are there for others without focusing directly on problem solving. Problem solving can indeed emerge from their efforts but that is not their overt intention. The most important thing these pastoral counselors try to bring to the situation is the faithful offering of themselves available, coming alone to visit and listen, drinking coffee together or sharing a meal, completing a small household project, running errands, accompanying patients on a visit to the doctor, going for a walk with them, visiting grave sites, sending a birthday card, playing together on the street, being there when a child takes her swimming test. Instead, the focus goes to the cultivating of caring relationships and the approach is deemed successful even when there is no evidence of concrete problems being solved.

Not knowing what the answers are in many difficult situations and in sharing people's stories of starkness, I have come to appreciate the narrative of a caring presence even more. I agree with Freedman and Combs (1996: xii) "coming from a not knowing position made me feel more comfortable and ethical by learning from the participants how their stories unfolded." In the beginning, this position felt very awkward. But it was such a great feeling being able to collaborate with the participants, not as my inferiors but as co-researchers, co-authors and partners. To remain faithful to the narrative approach I had to constantly reflect on what I was doing and how I was doing things. The ongoing and continuous reflection helped me to make deconstruction and reconstructing continuously and necessary practices.

²⁴⁷White (2002a:14)

6.8.1 Reflecting on my position

The ethics of accountability and transparency invited me to be open and honest with the group, regarding myself, my HIV status and to acknowledge the power afforded by my position within the research journey. I was aware of the limitations of my own local knowledges. I was also open to the group asking me questions; aware that the concept of reflexivity incorporates autobiography as Ruby (1982: 4) puts it,

To be reflexive (in reporting) is to be not only self-aware but to be sufficiently self aware to know what aspects of self are necessary to reveal so that an audience is able to understand both the process employed and the resultant produced and to know that the revelation itself is purposive, intentional and not merely narcissistic or accidentally revealing.

My ethical responsibility and commitment was to engage in reflexive research practice and to report reflexively in the final product. Sometimes I would ask questions about the questions, “Is this what you want to talk about? May I ask youIs it okay for you if we talk about.....?” Sometimes I would check, “How is this conversation going for you? Can you let me know if this conversation becomes uncomfortable for you?”

It was important to me to remain in a dialogical, de-centred but influential and ‘not-knowing’ position. I saw all the participants as experts in their own lives with their own knowledges or rather lived experiences. The ‘not-knowing’ position invited me into the participatory mode of consciousness²⁴⁸ which resulted from my ability to let go of all preoccupation with self and more into a state of complete attention. I was completely aware that I was not HIV positive and I was in no way an expert on the experiences of people living with HIV and AIDS. My expertise/influence lay in being an “architect of the dialogical process, the therapist is a participant observer and a participant facilitator of the therapeutic conversations”²⁴⁹.

In my therapeutic conversations with the participants I sought to be their dialogue partner and to co-construct with them a ‘truth’ for the time being, from a position where they stand for the time

²⁴⁸ Heshusius (1994:17)

²⁴⁹ Heshusius (1994:27)

being²⁵⁰. This position for the time being indicates a temporary position that is flexible and allows for reconsideration. It means choosing a truth or truths amongst the plurality of possible truths. Subjectivity is fluid because it is constantly being constituted and reconstructed by discourses at battle. By being attentive to this battle, the pastoral therapist can empower people to choose where they will stand²⁵¹. At the moment of the research journey, the participants chose to believe God as the healer of spiritual pain.

6.8.2 Reflecting on my use of narrative therapy

I want to use Freedman and Combs (1996:15-16) words to describe how I understood my use of narrative practices I chose for this research. They say,

We no longer try to solve problems. Instead we become interested in working with people to bring forth and thicken stories that do not support or sustain problems. As people inhabit and live out the alternative stories, the results are beyond solving problems. Within new stories, people live out new self images, new possibilities for relationships and new futures.

In a way, it was difficult for me to explain the effects of the narrative practices that I used as part of my philosophical stance to the group as I did not think these practices were always visible to them. Deconstruction for example could be seen as ‘asking too many questions’. Mai Paida for example once said that I didn’t give them answers to their questions but I asked them a lot of questions and that usually I would say, ‘I don’t know’. Of course we had a good laugh about this but I explained to the group that when I say I don’t know I was genuine I didn’t know the answer. But I asked them whether these questions were helpful and they all said ‘yes’. The other challenge I had was how to translate these practices into Shona for them to understand them. In most cases I ended up using Shona –English and we both found it working. For example “externalizing” we would say ‘*kuexternalizer*’. But they understood and appreciated the practice of externalizing. They would sometimes even correct each other when someone tried to own the problem then they would say for example, “my problem has been with me since I tested HIV positive.” Then the others would say, “the problem not your problem.” This helped them to

²⁵⁰ Bons-Storm (1998:18)

²⁵¹ Dunlap (1999:136-137)

separate the spiritual pain from the person and this assisted them to make decisions that brought about changes. The externalized way of talking about the problem was accepted by the whole group and alternative stories started to develop.

6.8.3 Reflecting on how I confronted my own fears

I have counseled and cared for HIV and AIDS patients for many years now but not in the same manner I did in this research. There were times when I would sit there with the participants wondering in my mind whether I could ever comprehend what they were going through. But whenever such fears rose up within me, I would confront them with the fact that I didn't need to understand their situation but to walk with them on their life's journey, not as an expert of their lives but as a compassionate partner. I tried by all means to use expressions like "I hear your pain." "I am sorry to hear that." "I understand this is a very difficult time for you." "What can I do to help?" I realized that, I cannot completely understand how anyone else is experiencing a particular situation but to imagine how difficult the situation was for them. This helped me to understand my limitedness as a person and as a pastoral caregiver too.

6.8.4 Reflecting on ethical considerations

The depth of the stories the participants shared with me and with the rest of the group required a high level of confidentiality, compassion and empathy. There were times when I listened to some of the stories and I felt like judging the participants but I always found my compassion for them to be stronger than judgment. I realized that they had already judged and condemned themselves several times. They didn't need my judgment. They needed compassion. Hence spiritual care that lacks compassion is not helpful to the people living with HIV and AIDS. By sharing such stories it meant the participants had become vulnerable and we were all obliged not to tell the secrets entrusted to us.

A critical and ethical consideration I had was the strong desire to uphold the maxim "above all do not harm." This meant ensuring that participants were in no way re-traumatized. Waldegrave (1990:7) explains, "We view the process of therapy as sacred. People come often in a very vulnerable state and share some of their deepest and most painful experiences. For us, these

stories are gifts that are worthy of honor.” In this regard, the vulnerability of the research participants is being highlighted and the risk involved in participating in a research project of this nature. In our conversations with the participants, I asked them if they would be able to tell or indicate to me at any given time if they felt their participation in the group or as individuals was causing them discomfort or more distress than benefitting. Holding this awareness meant creating space for ‘checking’ with the participants how they were in terms of the conversations taking place and encouraging them to take responsibility for their own lives.

Participatory conversations made me aware of not wanting to gain new knowledge at the expense of the participants. McTaggart (1997:4) warns against the “exploitation of people in the realization of the plans of others.” I found it very useful to work with the question, “who is benefitting in this research journey?” I worked with the commitment to a participatory action research process that would ultimately be primarily of benefit to the participants. When I asked one of the participants, Mother, about her motivation to volunteer for this study she said that she wanted others like her to benefit from her story and if her participation would help others to seek for spiritual healing, it would be worthwhile. Mukoma T.J added that, his motivation to join the study was to see if his participation may contribute to the improvement of care services for people living with HIV and AIDS at the hospital.

6.8.5 Reflecting on how psychosocial issues were dealt with

People living with HIV and AIDS deal with a lot or a variety of psychological and social issues which some of them were identified in this research as symptoms or manifestations of spiritual pain (Chapter Four). These issues were recognized and not ignored. However just working on them without attending to their spiritual root cause would not have been very helpful to the patients. It would just be like scratching on the surface. There were also times when I noticed that some participants bounced back and forth between various stages of grief. I offered support during these times. As a pastoral caregiver, I learnt that we cannot heal every wound and solve problems in one hour. Pastoral therapy with someone whose life has been touched by HIV requires time, patience and development of a relationship. It is not about answering every question. None of us can adequately deal with all their issues. HIV and AIDS raises concerns about death, prolonged illnesses, financial difficulties, stigma and discrimination and much

more. This required me to confront these issues and get in touch with my own emotions about them. I tried to respond to the needs of the persons and not my own anxiety, fear and pity. I also tried to be emotionally present and there were times when my touch, hug or presence was sufficient to convey my solidarity with the participants. We must realize when we have reached our limits and be willing to refer the patient to another person.

6.8.6 Reflecting on co-researching

One of the biggest dilemmas I struggled with was how to ensure that I was not imposing my ideas of what would be a good alternative story on the participants. I constantly reminded myself that it was important for me to acknowledge that this work involved co-authoring. As a researcher/pastoral therapist, I was involved in the process through the questions that I asked the participants and the beliefs that I paid attention to. But I wasn't the primary source of these stories. Through my questions I invited the participants to be the ones who did the interpretation of their experiences. These interpretations of what was important, what was preferred were not up to me to make. The other thing I tried to do was to constantly question any assumptions that I might have made. "Am I assuming what this person wants out of life? Am I assuming that this is a significant belief for them?"

I found it very important to remind myself that, re-authoring conversations were not linear, and did not follow a straight and narrow pathway, nor do they head in one direction. Sometimes when I thought it was time to talk about the alternative story, a session would occur in which the problem made a comeback and we had to talk more about this. I found out that it was important to spend a considerable time externalizing the problem and mapping the effects of it, really acknowledging the effects the problem was having upon their lives and their relationships. I saw all of this as setting the foundation for the re-authoring conversations.

6.9 Conclusion

There is still much more to be said about caring for people living with HIV and AIDS. Here is a short collection of what I have learnt together with the participants through the journey of the research. Listening to the voices of people living with HIV and AIDS in Zimbabwe brought the reality of the unimaginable and indescribable spiritual pain experienced by people living with

HIV and AIDS. As one who is not HIV positive, I can never claim to understand their pain, except to imagine how painful it might be. However, the reality of the spiritual pain and the need for spiritual healing among the people living with HIV and AIDS was a very disturbing experience for me. Understanding the vitality of utilizing the biomedical, Shona and Christian worldviews in the quest to find healing became imperative during the study. This helped me to appreciate the participants' instinctive eclecticism of the biomedical, traditional and Christian worldviews in their journey to spiritual wellness. Spiritual and pastoral care of people living with HIV and AIDS emerged as a strong suggestion and as a necessity. The wish of participants that their spiritual well-being be considered in their health care has added momentum to this expectation. Narrative therapy emerged as a therapeutic approach, which can be used pastorally to journey with people living with HIV and AIDS in their quest to find spiritual healing.

CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

7.0 Introduction

This chapter revisits the research question, the aim of the study and the research goals. The chapter also gives conclusions, limitations and recommendations made from the research journey. The research curiosity for this study was prompted by the HIV and AIDS policy in Zimbabwe that advocates for a holistic approach to the care of HIV and AIDS patients, within the primary health care delivery system. The recognition that, health care needs to be holistic, for the best outcome for people living with HIV and AIDS creates an expectation that spiritual care will also be incorporated into clinical practice. However, for some reasons, the spiritual dimension of being human in the quest to find healing has been ignored in the care of people living with HIV and AIDS within the primary health care delivery system of Zimbabwe and this has had the effects of reducing intervention programmes to purely medical, psychological and sociological. Hence the main question this study proposed to answer was, what could be the spiritual problems and needs of people living with HIV and AIDS from their perspectives and (if any), how can such spiritual problems and needs be addressed within the primary health care delivery system as part of the holistic approach to the care of people living with HIV and AIDS.

7.1 Research question revisited

The research question was: what could be the spiritual problems and needs of people living with HIV and AIDS from their perspectives and (if any), how can such spiritual problems and needs be addressed within the primary health care delivery system as part of the holistic approach to the care of people living with HIV and AIDS. The nature of the research question required me to choose a qualitative approach to research and I chose the participatory action research through the therapeutic lens of the narrative approach to research and therapy. The qualitative nature of the research required me to choose a theological and theoretical framework to inform the study. I

opted for the postmodern, feminist, participatory and contextual theologies, postmodern and social construction epistemologies. The framework proved to be suitable for the research study which was mainly informed by the stories and conversations of the research participants.

The first part of the research question was answered by the participants as they stated that their spiritual problem was spiritual pain which they experienced in their spirits. Hence their spiritual need was spiritual healing from the spiritual pain, which they experienced from living with HIV and AIDS. For the second part of the question, the narrative approach emerged as the therapeutic approach which can be used pastorally to journey with people living with HIV and AIDS in their quest to find spiritual healing. According to the participants God is the ultimate healer of the spiritual pain. This was the unique outcome which became the base for building the participants' alternative stories. Re-authoring conversations were used to assist the participants create their new emerging stories based on the unique outcome, "only God can heal."

7.2 Research aim revisited.

The aim of this research was to co-create a spiritual and pastoral approach to healing with people living with HIV and AIDS which is contextual and relevant to the Zimbabwean context as part of the holistic approach to care and counselling of people living with HIV and AIDS within the primary health delivery system. The philosophical ideas from the theological and theoretical paradigms chosen for this research made it possible to co-create spiritual care and pastoral therapy together with the participants since participants were positioned as the experts of their lives and the therapist assumed a not knowing position. This framework made the research/therapy to be a collaborative activity by means of which spiritual pain was shared and experienced in a manner that embraced subjective-integrity, rather than a structured inquiry that utilized accepting scientific methodology to solve problems. The narrative approach to research and therapy fitted very well with contextual, postmodern, participatory and feminist theologies by centralizing participants' stories and by not reducing them to being passive recipients of an expert professional. The story telling of the participants in their own voices and according to their own experiences centralized their own contexts and did not confine them to external theoretical classification systems, which pathologizes people. Narrative therapy from a postmodern, contextual, participatory and feminist theological perspective emerged as a

therapeutic approach which can be used in the process of co-constructing spiritual care with people living with HIV and AIDS within the primary health care delivery system in Zimbabwe by pastoral therapists. The aim of therapy was to facilitate the re-authoring of new-stories of hope which occurred in the presence of witnesses who influenced the re-construction of alternative stories of healing.

The use of the metaphor of a journey, which is a narrative way of engaging with people, was helpful as it conveyed the idea of a long term process and long term relationship in which, people live their stories with the intention of holding onto the narrative of time. In line with contextual, postmodern and feminist theologies, the pastoral conversations, the participants' conversations with God and their relationship with God were respected. As the participants articulated God as the healer of spiritual pain, God was invited into the conversations. The participants left it up to God to make the seeds of their faith grow. Therapeutic conversations and therapeutic gatherings were an 'in there' together process, where the participants talked with one another and not 'to' one another. Together with the participants we co-created, co-researched and co-constructed new meanings, new realities, new options and possibilities and new identities. My position was always one of ethical curiosity. I did this by asking questions in a tentative, curious and respectful way which opened space for new meanings to emerge. It was important to note that re-authoring of the preferred stories does not only occur in therapy as we are all constantly writing and re-authoring the stories that shape our lives. Re-authoring conversations seek to create the possibilities for the generation of the alternative, preferred stories of identity. Once these have been co-created then the person concerned will have a foundation to continue to build on the belief and create meanings around this new story even outside therapy. Therefore, narrative research/therapy doesn't end with a conclusion, but with an open ending which hopefully would stimulate a new story and new research and new therapy.

7.3 Research goals revisited

The first goal of the study was to establish the spiritual roots of HIV and AIDS from the perspective of people living with HIV and AIDS. Chapter four began by focusing on the spiritual root causes of HIV and AIDS according to the participants as a backdrop to their spiritual needs. The issue of spiritual root causes of HIV and AIDS stemmed from the participants' descriptions

of their lives as being very difficult which they described metaphorically as carrying a heavy burden. I became curious and wanted to know why they termed the 'new life', which they all described as a heavy burden, when ART had removed the fear of death from them. From the conversations that followed it became very clear that the greatest challenge faced by people living with HIV and AIDS is now, living an HIV positive long life, taking ARVs daily knowing that there is no cure for AIDS. The participants in the study confirmed the Shona thought, that there is no such thing as an event without purpose. Shona people must always look beyond the physical manifestations of the disease to the spiritual etiology of the disease.²⁵² The participants also confirmed another Shona thought that, any illness or sickness has a cause or causer and the question why the HIV has infected a certain individual and not the other must be answered.

The locally claimed realities of people living with HIV and AIDS who are the co-researchers in this research journey in various capacities were honored by giving them a chance to speak as theologians in this academic discourse. Some of the participants confirmed that, the Shona believe that the dead still have influence in the lives of the living as it was also observed that the causes of illnesses are believed to be of a direct consequence to the breaking of taboos and offences against God or ancestral spirits, In this regard, God is linked to the spiritual etiology of HIV and AIDS through the ancestors who though dead, are still interested in the lives of the living. Some of the participants also confirmed the Shona thought that illness, that are not easily treated are due to the active intervention of an agent, like a witch, a ghost, ancestor or an evil spirit (5.2.2). Witches in the African societies are believed to be the authors of evil causing misfortunes, bad luck and sickness Therefore, in terms of illness ancestors are seen as having failed to protect the victim from being bewitched because they are angry with the victim. The other participants confirmed that when the ancestors are angry with the person, automatically God is also unhappy with the individual. God or the ancestors often punish people who have failed to live up to their obligations. Given the African concept of sin, HIV and AIDS is clearly a sign that the harmony between the God, ancestors and man has been broken.

The participants made it clear that God is not necessarily seen as the direct origin of HIV and AIDS, or of all suffering and sin but He is somehow linked to it. When there is a broken

²⁵² Graves, (1988: 103)

relationship between the spiritual realm and the person that creates a gap, which allows the virus to enter the body of the person. Hence, whatever is not right spiritually manifests physically as a disease and in this case as HIV and AIDS. Therefore, for healing to take place the spiritual healers had to be consulted. The participants made it clear that their first call for help was to consult the traditional healers or the prophets as the spiritual healers. According to the participants' perspective what comes first is not the HIV infecting the body but the broken relationships which create a gap between the individual, other fellow humans, the living dead and ultimately God and that allows the virus to infect the person.

The other goal of this research was, to develop an understanding of the spiritual needs of people living with HIV and AIDS who are receiving care within the primary health care delivery system. This became the main focus of Chapter Four. The research participants articulated their need for spiritual healing from the spiritual pain which was in their spirits. The spiritual pain, since it was invisible, was described by some as the inner pain, the inner struggle or troubled spirit. According to the participants, every person has a spirit, which does not die and this is the human part where the spiritual pain is experienced in this context. The Shona understanding of the human person having a personal spirit, agrees with the Biblical account of the creation of people according to the Shona Bible which causes a contradiction when it comes to the English Bible which talks of the soul of which there is no Shona word for soul. Through our therapeutic conversations, with the participants, in an attempt to further deconstruct and understand spiritual pain of the co-researchers, I wanted to know how the spiritual pain being an inner struggle affecting the spirit of the person and how it can manifest to provide a clue for healing. I wanted to know from the participants how the spiritual pain operated in their lives? How did it show up since it is invisible? How did it work? And what sustained the spiritual pain?

The participants explained that spiritual pain manifested in different ways in their life. It manifested as anger, isolation, hopelessness, meaninglessness, doubt, abandonment confusion about God's love, guilt and guilt feelings, unforgiveness and internalized homophobia. Then I asked the participants what they really wanted. The seven participants agreed that, they wanted to be healed from the spiritual pain and their hope was in God as the healer. I then became interested to find out from the participants whether the belief that, God can heal the spiritual pain

stood out to be something important to them and the answer was ‘yes’ because there is nowhere else they could turn to for help. I became curious to find out from them whether God the Creator/*Musikavanhu/Mwari* who they describe as almighty and powerful can become a personal God who they could ask questions and heal their spiritual pain. This unique outcome²⁵³ became the base for chapter five. The co-researchers brought God into the conversations and this was not a forced effort by me to bring God into the conversations. It was an honest undertaking in order to hear and understand the co-researchers’ religious and spiritual understanding and experiences of God’s presence in their lives and how He was going to heal them. From then on, God became the ultimate focus and an integral participant in our conversations.

The other goal of the study was to search for an understanding of the role that traditional beliefs and customs play in people’s perceptions towards the Western epidemiological understanding and interpretation of the HIV and AIDS pandemic in Zimbabwe. The concept or the role traditional beliefs and customs play in people’s perceptions of HIV and AIDS was acknowledged throughout the research, by positioning people living with HIV and AIDS as co-researchers and as experts of their lives as people who live in a multicultural and multireligious country at a very specific time in the history of Zimbabwe. In searching for this understanding, the research journey tried to explore what the transition to a postmodern, contextual, feminist and participatory worldviews had to offer to practical theological reflections in the context of working with people living with HIV and AIDS in a changing, fragile and ever-changing postmodern time. The philosophical ideas of post modernity as an epistemology of this study became useful in the search for this understanding, because they acknowledge that objective knowledge is impossible and therefore, multiple realities are preferred since there are no universal criteria for the truth claims to knowledge.

On the other hand, the contextual approach of doing practical theology became useful because it starts from the life situation of people and proceeds from there to reflection, which is a grass roots approach rather than a top-down attitude and this form of practical theology, with its “from below” communication style, suggested that communication should involve the experiences and

²⁵³ Freedman and Combs(1996:77) describes unique outcome as sparkling events that contradict problem saturated narratives.

expectations of people living with HIV and AIDS themselves. Hence, the theological conversations in this study entailed a “talking with” an “in there together” process in which the issues at hand were co-explored towards resolution and hope. The participatory approach to practical theology not only helped us to recognize the local nature of knowledge, but also the local theologies of participants and the constructedness of theology within individual communities. Acknowledging that theology is always contextual as it is set in some context and rooted in some life experience, it is clear that with these knowledges, it is impossible to voice large truths. And all we could do was to voice local truth and propose that it pertains elsewhere.

However, it appeared in this study as if the participants have developed an instinctive eclecticism as a way of coping with the different but competing models of understanding HIV and AIDS rather than sticking to their traditional beliefs about the disease. The participants tried to harmonize the three worldviews i.e. traditional beliefs, Christian faith and the Western scientific worldviews in their existential circumstances to try and understand the disease as well as in seeking for healing. All the participants affirmed that when they became sick, their first call for help was to go to the traditional healers as is their custom. Then from there they went to the faith healers and finally to the hospital. The mission of those who went to the traditional healer and the faith healer was to ascertain the spiritual cause of the illness. The mission of those who went to the medical doctor was to ascertain the natural cause of the illness.

The three different and often taken as antagonistic worldviews were seen as kind of complementing each other. Put together the three worldviews constitute an eclectic patchwork that the participants have come up with to negotiate their way and deal with the existential realities of HIV and AIDS facing them in contemporary Zimbabwe. However, in terms of spiritual healing of people living with HIV and AIDS the Shona traditions, the church and the scientific modern medicine, the three put together, have failed in this regard as articulated by the participants in this study. Now HIV and AIDS has gone beyond the expertise of the traditional healers, ancestors, the church pastors and prophets, and the scientific doctors. Hence the need for spiritual healing among the participants is unimaginable. The strong suggestion emerging from this study is that, spiritual care and pastoral therapy of people living with HIV and AIDS, must of necessity be integrated into the holistic approach to the care of people living with HIV and

AIDS in Zimbabwe. The wish of participants that their spiritual well-being be considered in their health care adds momentum to this suggestion.

7.4 Conclusions

The conclusions given here are done with the aim of giving summaries to each chapter as written in this dissertation.

7.4.1 Chapter One

The aim of Chapter one was to give an overview of the research journey, by highlighting that Zimbabwe is one of the worst countries affected by HIV and AIDS in the entire world and the consequence has been widespread death and massive suffering among the people. This background also highlighted that Zimbabwe has to confront a number of severe crises in the past few years including, an unprecedented rise in inflation, a severe cholera outbreak, and high rates of unemployment, a tense political climate and a near total collapse of the health system. Hence, responding effectively to the pandemic has been difficult and the suffering on the people continues to amount to unimaginable heights of pain affecting all segments of society but hitting hard on women and children. As such, the Government of Zimbabwe (GOZ) started responding to the impact of HIV and AIDS in 1987 through the Ministry of Health and Child Welfare and by 1990, the President Robert Mugabe called for a multi-sectoral and multi-disciplinary response to mitigate the impact of HIV and AIDS on the people. In this regard the GOZ through the Ministry of Health and Child Welfare established the National AIDS Action Committee (NAC) to coordinate the national HIV and AIDS programmes and in 1999, the NAC finalized two important policy documents to guide the national response to the pandemic which are, *The National Policy on HIV and AIDS for Zimbabwe and the Strategic Framework for a National Response to HIV and AIDS*. In this policy the care of people living with HIV and AIDS is integrated into the primary health care delivery system. The National Policy on HIV and AIDS policy of Zimbabwe advocates for a holistic approach to care of people living with HIV and AIDS. However the policy is silent about the spiritual care of people living with the disease. To me, excluding the spiritual needs of people living with HIV and AIDS from the above policy is a

huge gap, which called for research and ignoring the spiritual needs of patients, defeats the purpose of a holistic approach to their care.

I wanted to establish through this study that, people living with HIV and AIDS have spiritual needs, which should be addressed in a holistic approach to their care within the primary health care delivery system. I wanted to study and understand the spiritual issues and concerns of people living with HIV and AIDS from their perspectives, which are being overlooked within the primary healthcare delivery system in Zimbabwe. I wanted to learn from the people living with HIV and AIDS what could be the spiritual root causes of HIV and AIDS and how can they be addressed within the primary health care delivery system in Zimbabwe. Therefore, the aim of the study was to co-create a spiritual and pastoral approach to healing with people living with HIV and AIDS, which is contextual and relevant to the Zimbabwean context as part of the holistic approach to care and counselling of people living with HIV and AIDS within the primary health delivery system. In line with the aim of the research, the goals of this research were, to develop an understanding of the spiritual needs of people living with HIV, find out from them what they considered to be the spiritual roots of HIV and AIDS and to find ways of making pastoral care and counselling to people living with HIV and AIDS relevant and contextual within the primary health care delivery system in Zimbabwe. And to achieve this, a suitable theological and theoretical framework was needed to position the research. I chose to do a qualitative research informed by the philosophical ideas of postmodern, participatory, contextual and feminist theologies, postmodern and social construction epistemologies, and participatory action research through the therapeutic lens of the narrative therapy. This framework was further expanded in Chapter Three.

7.4.2 Chapter Two

Chapter two aimed at highlighting the HIV and AIDS epidemiology, its evolution in Zimbabwe and the national response to the pandemic with the view of trying to understand the context in which the spiritual needs and concerns of people living with HIV and AIDS who are receiving care within the primary health care delivery system in Zimbabwe are embedded in. The chapter based on literature review, discussed how the GOZ has responded to the HIV pandemic and the role played by international organizations in mitigating the impact of HIV and AIDS on the

people. The main focus therefore was on the Zimbabwe National AIDS Policy (ZNAP) and how the care and counseling of people living with HIV and AIDS within the Primary Health Care delivery system is viewed. I concluded by discussing what I considered as the missing gap in the (ZNAP) which is, the silence on the spiritual care of people living with HIV and AIDS as part of the holistic approach to the care. To enhance the background to the study, the geographical and historical context of Zimbabwe was discussed.

Chapter two also highlighted the importance of the context in which the HIV pandemic is embedded based on the opinion that all societies are complex, multi-faceted, having innumerable features that might be measured and tested for their potential contributions to the configuration of health and disease²⁵⁴. Hence in Zimbabwe, the HIV and AIDS pandemic cannot be understood outside the social, economic and political context of Zimbabwe which to some extent determines the evolution of HIV and AIDS in Zimbabwe. The social determinants of HIV and AIDS discussed were the gendered dimension since the highest mode of HIV transmission in Africa and in Zimbabwe is through penetrative heterosexual intercourse or contact of which the societal social ideology surrounding sex, gender and power relationship is inevitably reflected and constructed in HIV and AIDS discourses. And the way gender and sexuality are constructed in the HIV and AIDS discourse has some bearing on the evolution of the pandemic. The chapter noted that to some extent some Zimbabwean cultural practices shape and perpetuate gender inequality and strip women of any form of control over their sexuality due to the fact that, custom in Africa is stronger than law and religion. The chapter also pointed out that Zimbabwe is one of the poorest countries globally and highlighted how the economic difficulties experienced in the country in the past and present, have fueled and sustained the HIV and AIDS pandemic. The migrant system of labour in Southern and East African countries as well as urbanization contribute to family separation and the spread of diseases (including AIDS) from urban to rural areas as well as in the opposite direction.

The chapter also pointed out that GOZ called for a multi-sectoral approach to AIDS guided by the National Policy on HIV and AIDS which adopted a public health care approach known as the Primary Health Care (PHC) approach to HIV and AIDS services, treatment and care of people

²⁵⁴. UNAIDS (2001:21) acknowledges that the political, social and economic context determines the HIV pandemic.

living with HIV and AIDS, which is done within the health care delivery system. Voluntary Counselling and Testing for HIV is done within the system as an entry for HIV prevention, care and treatment. The chapter highlighted that PHC in Zimbabwe has a colonial foundation that continues to plague it and its users. Western biomedical model of health care, treatment and counselling is unequivocally the only valid paradigm for official health care. Psychological counseling being offered to people living with HIV and AIDS within the PHC addresses their emotional, social and psychological needs as indicated in the HIV and AIDS policy. My argument in this regard was that, offering psychological HIV counseling within the PHC in isolation from spiritual care and counselling would appear to defeat the objectives of a holistic approach to care and counseling of people living with HIV and AIDS.

7.4.3 Chapter Three

The aim of this chapter was to give “voices to the voiceless” by “storying the unstoried” experiences²⁵⁵ of being HIV positive for the purposes of exploring how their spiritual problems and needs can be addressed within the primary health care delivery system in Zimbabwe. The stories in this dissertation are true although names and minor details have been changed to obscure identities. I endeavored to tell each participant’s story faithfully and I intentionally refrained from interpreting or commenting about each story and each story is treated with dignity and as unique and important²⁵⁶. The chapter made an attempt to emphasize the participant as a knower and therefore, to distance myself from the biomedical approach to the care of people living with HIV and AIDS. which assume that patients do not know and have to get the knowledge from outside. The position of the thesis is that no one is completely without knowledge but rather, people may know different things depending on their social positioning and circumstances.

The stories of the participants represent their own experiences and are not necessarily representative of the lives and experiences of other people living with HIV and AIDS in Zimbabwe or anywhere else on the globe. This is in line with the postmodern, contextual and participatory epistemological perspective, where reality is not perceived as an objective given,

²⁵⁵ Isherwood and McEwan (1998:87)

²⁵⁶ Eberhardt (1996:24),

but instead knowing is seen as inherently contextual because within these approaches the knower helps constitute what is known. In this chapter, the people living with HIV and AIDS' voices are heard. By inviting the voices of people living with HIV and AIDS into this research, I wanted to understand their experiences of living with HIV and AIDS and as background to studying their knowledges as well as ideas about their spiritual needs. Part of the purpose of the study was to deepen the co-researchers' own understanding of their HIV and AIDS experiences as backdrop to identifying their spiritual needs from their own perspective. Therefore, in this chapter I gave the participants a voice, which could be heard among the many other voices that speak of the experiences of living with HIV and AIDS.

7.4.4 Chapter Four

Chapter four focused mainly on answering the first part of the research question by identifying the spiritual needs of people living with HIV and AIDS. Part of the purpose of this chapter was to deepen the co-researchers' own understanding of their spiritual issues and concerns under consideration to the extent of identifying the spiritual root causes of HIV and IDS from their own perspective. The chapter captured the explanations made by the participants of the indescribable and unimaginable spiritual pain experienced in their spirits, which the traditional healers, the faith healers or prophets have failed to heal. The participants also expressed how the spiritual pain manifests in their lives. It was tempting to over simplify this chapter about the spiritual needs of people living with HIV and AIDS and yet the truth as we discovered was, an essential part of understanding the spiritual needs of people living with HIV and AIDS is to recognize that it is as complex as the disease itself. The seven participants were able to articulate what their spiritual needs were. It emerged that the participants' stories of pain suffering although different, their spiritual needs were the same. Their spiritual needs were amply stated as spiritual healing to the experienced spiritual pain expressed in the spiritual outcry why me? The participants clearly stated that only God can heal them since everything else has failed. This therefore emerged as the unique outcome on which all their stories converged for building the alternative stories which were re-authored in Chapter Five. The fact that the participants pointed out that only God can heal them from their predicament indicated that spirituality within the postmodern paradigm can

be a resource which can be used in supporting people living with HIV and AIDS on their personal spiritual paths to find healing.

The participants in this research well articulated their quest for spiritual healing. Hence the need for their spiritual well being is to be considered within the PHC delivery system in Zimbabwe. The chapter based on the participants' conversations, concluded that the recognition by the policy makers that healthcare needs of patients has to be holistic and that it is the whole person to be cared for, for the best outcome for patients, exerts an expectation that spiritual care should also be incorporated into clinical practice in order to address the spiritual needs of patients. If this be the case, then surely it is the clinical staff who should be responsible for the patient's mind, body and spirit. Hence pastoral care as spiritual care emerges as the best spiritual and pastoral approach to journey with the patients on their personal spiritual pathway to spiritual wellness. This was further developed in the following chapters. My assertion based on this study, is that given that, eighty percent of Zimbabwean people believe in God or higher power, ignoring matters of spirituality is disastrous to a holistic approach to care of people living with HIV and AIDS.

7.4.5 Chapter Five

This chapter focused more on answering the second part of the research question having established in the previous chapters that people living with HIV and AIDS quested for spiritual healing, which was necessitated by the indescribable and unimaginable spiritual pain expressed in all their questionings. This chapter described how spiritual healing, as a spiritual need of persons living with HIV and AIDS can be addressed using narrative therapy. The goal of therapy was not to counsel or to take away the disease or to offer a 'healthy dogs'- myths about quick fixed solutions and things that work²⁵⁷ but to mobilize the spiritual resources within the participants to enable them to cope. The idea was therefore, to empower those living with HIV and AIDS to discover their own spiritual potentials, which would enable them to work through their spiritual pain. This was clearly not an easy task for both the participants and me, but it carried the potential for growth and for healthier functioning in the present and gave perspective on a better future. The chapter also aimed at co- creating a therapeutic framework pastoral

²⁵⁷ Muller (1999:61)

caregivers can use to journey with people living with HIV and AIDS in quest for healing. The narrative therapy emerged as the therapeutic approach which can be used pastorally to journey with HIV and AIDS patients on their personal spiritual pathways to spiritual healing.

The chapter described the processes of the re-authoring of people's lives based on the unique outcome that, only God can heal brought forth alternative stories. The alternative story is often anti-problem and brings forth people's skills, abilities, competencies and commitments on their personal pathways to spiritual well being²⁵⁸. The participants understood God as the ultimate healer who becomes involved in human history and in their suffering²⁵⁹. All narratives have a cry for help in which, most of the time society and the medical doctors may ignore. My position as a pastoral caregiver was not only to participate in constructing the alternative stories but also care in a way that could heal and not hurt. My purpose and desire for this study was to enable the participants discover new ways of authoring their lives, through participation in the study as the experts of their lives. A strong suggestion that emerged from this chapter was that, spiritual care of persons living with HIV and AIDS who are receiving care within the PHC is needed and it is possible as long as space can be created and the qualified clinicians are made available to the people living with HIV and AIDS. The chapter concluded that spiritual care, as integral to holistic patient care in Zimbabwe is largely embraced in policies but not so much as such in the implementation of the policies. Therefore, the spiritual care of people living with HIV and AIDS can be viewed not as an option but a necessity within the holistic approach to the care of people living with HIV and AIDS. The wish of participants that their spiritual well-being be considered in their health care adds momentum to this suggestion

7.4.6 Chapter Six

The purpose of this chapter was to reflect on the research journey and its effects on me as the researcher/therapist as well as on the research participants. New questions were posed and challenges experienced during the research process were discussed as the reflections were done. Although reflection on research/therapy, was done throughout the study as the journey progressed, the purpose of this chapter was therefore to emphasis the importance of reflection as

²⁵⁸ Morgan (2000:59)

²⁵⁹ Louw (2000:83).

an important learning activity and as a continuation of the co-research. It is through the experiences of reflecting on our experiences that we make meaning of it. The chapter emphasized that, reflection is a particularly necessary process as a postmodern/social constructionist ethics in which the researcher/therapist and the participants function. The ethical positives on which this reflection was based valued openness, transparency, de-centering of the researcher/therapy, subjective-integrity, honesty and the deconstruction of any power relations that might exist. The reflection in this chapter was done according to how the philosophical ideas from the theological and theoretical frameworks influenced the research journey in the quest to find spiritual healing from the spiritual pain experienced by people living with HIV and AIDS.

As I reflected on the research journey, I came to realize that there is still much more to be said about caring for people living with HIV and AIDS. The chapter gave a short collection of what I have learnt together with the participants through the journey of the research. Listening to the voices of people living with HIV and AIDS in Zimbabwe brought the reality of the unimaginable and indescribable spiritual pain experienced by people living with HIV and AIDS. As one who is not HIV positive, I realized that I can never claim to understand their pain except to imagine how painful it might be. However, the reality of the spiritual pain and the need for spiritual healing among the people living with HIV and AIDS was a very disturbing experience for me. Understanding the vitality of utilizing the scientific, Shona and Christian worldviews in the quest to find healing became imperative during the study. This helped me to appreciate the participants' instinctive eclecticism of the three worldviews in their journey to spiritual wellness. The chapter concluded by stating that, spiritual care of people living with HIV and AIDS emerges as a strong suggestion and a necessity. Narrative therapy emerged as the therapeutic approach which can be used by pastoral caregivers to journey with patients on their personal spiritual pathways to spiritual healing.

7.5 Limitations of the study

In this research, limitations were not seen as something to be resolved, but as boundaries and difficulties to be aware of. One evident limitation was that of trying to do research and therapy together throughout the research journey. I tried by all means to be aware of these boundaries but at times it would be difficult to do that. The two continued to blur and spill into each other that I

felt them as one. However in as much as it was difficult, the rich amount of information shared by the participants was so much and I appreciated that the participants gained in various ways from being part of the study.

Another limitation noted in the study was in trying to explore a connection between theological and theoretical frameworks I chose for the study maybe because of the self-contained worlds that many philosophical paradigms occupy. Scott (1990:58) states this difficulty in the following;

Feminist, Marxist, Liberals and so on, construct different facts and have frequently been both unable and unwilling to establish conventions for translating statements from one framework into another. Indeed, it is sometimes argued that theoretical positions occupy a completely, enclosed cultural world and that mutual intelligibility is impossible.

Although I do not believe integrating philosophical ideas is impossible, I realized that it was far from being an easy task. My experience in the research journey was that, the different frameworks have their own focus, history of development, language and perceptions. So trying to interpret the use of language and the understandings developed within varying philosophies was not easy. However, whilst acknowledging the difficulty in this, similar uses of language and common understandings were also evident and were utilized within the study.

On the other hand, trying to bring different philosophies together in a meaningful way raised the problem of eclecticism. My experience helped me to acknowledge the insight to be gained by the eclecticism and the contracting aspects of connecting the different paradigms. However, gathering parts of theories and then linking them to other aspects of other theories can lead to the essence of the work being negated. I tried to avoid this by gathering and using the primary philosophical ideas within these frameworks. However, the challenge was the use of specialized knowledges expressed in specific language, which needed translation to the participants in other circumstances. In some situations no Shona word could be used and Shona-English was used. I attempted in my writing to make the research report as accessible as possible, so as to avoid a labyrinth of knowledges although I am not sure how successful I have been in doing this.

The acknowledgement of limitations is essential as it allows for the research work to be used cautiously as it identifies areas where development and improvement is needed. It also leads to a

consideration of what direction future research might take. However, I think I managed to conduct a dialogue between the different frameworks fairly well and the participation of the co-researchers contributed to that success. In the process of forming my work, I was aware of the inherent inadequacy in attempting to describe, explore and depict the depth of spiritual issues and concerns of people living with HIV and AIDS.

7.6 Research Findings

Throughout the research journey, I wanted to establish that people living with HIV and AIDS have spiritual problems and spiritual needs which should be addressed within the primary health care delivery system in Zimbabwe as part of the holistic approach to their care. Besides the somatic, social, psychological and moral dimensions of the pandemic on the people's lives, the focus of the study was on the spiritual dimension. From the stories of the participants (chapter three) it is clear that, apart from the psychological and physiological implications, the spiritual dimension of life contributes to the complexity of the HIV and AIDS scourge. In an attempt to address the despair of people living with HIV and AIDS, traditionally secular counseling has steered away from incorporating matters of faith and spirituality into the psychodynamic setting and too often, this is considered the role and domain of clergy and traditional healers. Psychological models of counseling are based mainly on the medical model of curative approach. For many people, it is their spirituality that helps them cope with illness, trauma, loss and death. But for some reasons spirituality within the quest for healing has been consistently overlooked within the primary health care delivery system. However, this research has shown that spirituality as a hidden treasure can be a vital resource towards the spiritual healing of people living with HIV and AIDS. Human dignity is uplifted through deep respect for the uniqueness of each individual's spirituality. Therefore, the spiritual care of people living with HIV and AIDS can be viewed not as an option but, as a necessity within the holistic approach to the care of people living with HIV and AIDS.

A very interesting and valid point of the research is the fact that the research also wanted to probe into the dimension of human relationships as embedded in local, cultural contexts. The stories told by the participants in this study clearly indicate that HIV and AIDS is more than an infected body and it usually has to do with infected relationships (4.2.1.4). HIV and AIDS is

therefore, primarily a relational issue that needs thorough pastoral attention and intervention in order to attain a holistic approach to health and healing within the helping professions. The research affirms that a human person should be regarded as a relational and social being acting within a cultural context, making the being of the person more important than the function of his/her body. The research therefore, ascertains that because of the tremendous influence of a Western biomedical model in the primary health care delivery system, it becomes imperative to address the issues of health and illness within an African context. To put it differently, it is not the physical manifestation of the disease (which is but a symptom) that has to be healed, but the broken relationships among people, the environment and God (which is the real illness.) Then we can talk of spiritual health or wellness when the person experiences wholeness within the self, with other human beings, living entities, and transcendence with God.

Another valid point is the fact that, the success story of Anti-retroviral therapy (ART) suddenly opened the eyes of researchers in both the humanities and the medical professions, for the human quest for spirituality and questions regarding the quality of life. The success story of ART reveals the fact that people living with HIV and AIDS have become more concerned about life than dying (4.2). Hence, the argument that the primary focus of therapeutic intervention is to enhance the quality of life; lifelong support and care become imperative; caring for people entails maximizing the quality of life. The study focuses on the existential, relational and spiritual features of the pandemic which requires a spiritual and pastoral approach to healing that demands a focus on a concrete contextual approach (1.2).

The research also emphasizes the position of people living with HIV and AIDS which they can inhabit and lay claim to the many possibilities of their own lives that lie beyond the expertise of medical care. Medical care has developed to the extent where the patient is no longer the central figure. The entire human being can be reduced to a physical, biological or chemical entity to be analyzed and as a result of the power of the physician; the modern scientific understanding of life has gained a pseudo-religious character²⁶⁰. In this regard, a biomedical model holds the real danger that it can easily degrade human beings to the level of mere objects by ignoring the spiritual and cultural dimensions of life. Patient's knowledge has little room in the scientifically,

²⁶⁰Louw (2008:38)

tested and proven body of knowledge. In essence, the research emphasizes that there is no one without knowledge since the knower constitutes that which is known. In this regard, the people living with HIV and AIDS are the experts of their lives and have a great input in determining their well being. The present research journey conditions an attempt to emphasize the patient as a knower and therefore differs from the biomedical approach to the care of people living with HIV and AIDS, which assumes that patients do not know and have to get the knowledge from outside. The position of the thesis is that, no one is completely without knowledge but rather people may know different things depending on their social positioning and circumstances. There is also a two-way exchange of knowledge and information between those that were traditionally regarded as ‘knowers’ and those that had to be given the knowledge.²⁶¹

The main outcome of the study was the identification of spiritual pain and its manifestations by the participants. The participants used metaphors such as inner pain (4.4.1), the struggle inside (4.4.4), and a troubled spirit (4.4.3) to describe what they understood to be spiritual pain. The participants went further to explain that spiritual pain was not physical pain but that it was felt in the human spirit or in the spiritual dimension of being human (4.4.5). The participants went further to describe how spiritual pain shows up and how it operates and manifests in their lives. They identified the following existential issues as the manifestations of spiritual pain; anger (4.4.6.1), hopelessness (4.4.6.4), doubt and meaninglessness (4.4.6.2), isolation and abandonment (4.4.6.3), confusion about God’s love (4.4.6.5), internalized homophobia (4.4.6.6), guilt and guilt feelings (4.4.6.7). It is against this background of spiritual pain that the participants quested for spiritual healing. God became linked to their spiritual need as the healer of spiritual pain (4.5.1). God became the ultimate focus and an integral participant in the conversations as the healer of the participants’ spiritual pain. These conversations gave birth to the re-authoring of the alternative stories where the spirituality of the participants emerged as a vital resource in their quest to find healing. The research does not claim to have the solutions or quick fix miracle to the complicated spiritual pain of people living with HIV and AIDS and neither claims to have the power to bring any neat conclusions to the spiritual healing of people living with HIV and AIDS. However, the research has the potential to stimulate a new story of spirituality as a vital resource

²⁶¹Woolger (1983:244).

in the healing process of people living with HIV and AIDS and ignoring it may defeat the purpose of a holistic approach to the care of people living with HIV. The re-authoring of alternative stories is an ongoing process but like in all journeys, there are landmarks that indicate achievements, places of transfer or starting new directions or turning around. Hence this research process may be regarded as a landmark that indicated a new direction in the participants' journey towards spiritual healing.

In the light of these research findings, it became evident that there is an existing need within the Primary Health Care delivery system in Zimbabwe to provide spiritual care to people living with HIV and AIDS. The strong suggestion emerging from this study is that a spiritual care approach to healing must of necessity be integrated into the holistic approach to the care of people living with HIV and AIDS in Zimbabwe. The wish of participants that their spiritual well-being be considered in their health care adds momentum to this suggestion. Hence the research argues for the inclusion of a spiritual and pastoral approach to healing which links the patient's spirituality and pastoral care (1.2) in which those living with HIV and AIDS as well as those working with them can be empowered to re-author the stories of patients' lives around their self preferred images. The narrative approach was explored in this research as a possible therapeutic approach that could be used to journey pastorally with people living with HIV and AIDS in a non-controlling, non-blaming, non-directive and not knowing guiding manner that would permit the people living with HIV and AIDS to use their own spiritual resources in a way that can bring spiritual healing to their troubled spirits. The following recommendations were made against the background of these research findings.

7.7 Recommendations

The following section gives the recommendations made by the research participants first, and then follows the recommendations for practical theology and pastoral theology, pastoral care and the use of narrative therapy in pastoral care. I also make recommendations to the primary health care delivery system in Zimbabwe. I finally give recommendations for future research.

7.7.1 Recommendations from research participants

The participants in this research journey well articulated their quest for spiritual healing hence the need for their spiritual well being to be considered within the PHC delivery system in Zimbabwe. Here is what the participants said in this regard.

Mukoma K.K

I have benefitted a lot by being in this group. I know from now on I will look at life differently. I know I am not yet healed but I am on my way there. My request to the hospital authorities and to the Ministry of Health is that they should consider our need for spiritual healing. People living with this disease are going through a lot and such caring services like what we experienced by being in this group can go a long way in improving the quality of their lives considering that there is no cure for the disease.

Mai Paida

I was dying inside before I came into this group. My life was meaningless. I was lonely and confused. I had come to the end of myself that is why I was talking about having another child. I thought having a child would prove to people that I was not HIV positive. I also thought having a child would take my mind away from the deep pain in my spirit. But what happened to me here has transformed my life. I have stopped asking God all those questions. I am happy again and I don't need a baby to make me feel HIV negative or to prove a point to people. I have accepted my HIV status and I am on my way to spiritual healing to help me cope with the disease. My appeal to the government is that we need spiritual care to be part of our hospital services as people living with HIV and AIDS.

Mukoma T.J

When I look back from day one when we started sharing our stories of pain and where we are now it is a miracle. My heart goes out to our fellow friends who have not experienced what we experienced here in this group. My wish is that if the government could consider our spiritual well-being to be equally important as our physical being. As we have doctors and nurses taking

care of our physical needs as patients I think we also need other doctors to take care of our spiritual needs as well.

Mukoma Tippy

The stories of our pain and suffering we have shared together and the support we have given each other has been great and I will always remember it. I had come far with my struggles but being in the group helped me find fellow travelers who helped me to carry the burden. The inside pain is no longer as painful as it was before. I know I am on the right path to healing and God is now in charge of that pain. My desire is to see one day spiritual care becoming a reality for every person living with HIV and AIDS. I appeal to the government to help us receive spiritual care within the hospitals to help us cope with the effects of the disease on our lives.

The research journey has demonstrated that there is a two way approach of sharing knowledge because there is no one without knowledge. People know different things at different times. The difference is to be celebrated and not to be a cause for dispute. People living with HIV and AIDS, as experts of their lives, need to be acknowledged within the HIV and AIDS discourses. The current HIV and AIDS debate has largely excluded ordinary citizens who are living with HIV and AIDS and yet, they are the ones who know what it is like to live with the virus. The conversations about HIV and AIDS are regarded as discourses between ‘experts’ in which their contribution either does not count or could not be useful. The patients’ voice is often the most important but rarely heard. People living with HIV and AIDS need spaces where they can define the problem as they experience it contextually and locally. As they experience the problem in their communities, they can propose solutions as equal partners with government and civil societies. The HIV and AIDS discourse must become inclusive so that the needs of people living with HIV and AIDS can be reflected in policy designs at every level of government. When citizens become active in facing up to problems such as HIV and AIDS with policy makers and planners, they develop capacity and confidence to take ownership and responsibility for common concerns in public life. The point here is that, as people living with HIV and AIDS interact with the professionals as equals we can collectively continue to learn with each other about alternative ways of caring for people living with HIV and AIDS.

The participants in this study shared the need for training in basic spiritual and pastoral counseling. Hence the participants recommended that there should be space created for such training to be made available to them so that they maybe more competent to assist others who may be experiencing spiritual pain..

7.7.2 Recommendations for Practical Theology and pastoral theology

From the study, I want to recommend the postmodern theology to practical theology because of its critical stance towards all knowledges, including spiritual matters. Knowledge and truth are considered to be pluralistic, temporary, local and contextual. Hence pastoral caregivers become interested in how knowledge is constructed in therapy than what the knowledge is. This allows pastoral theology to shift from an objective claim of hegemony to a contextual and local perspective. In therapy conversational space is created that welcomes the plurality of meanings attributed to the concept of spirituality. The construction of spirituality happens within a particular social system, language and relationships in this construction are emphasized. Hence more than one level of reality is present in the therapeutic conversations which would apply to the particular spirituality of the patient that is culture and context specific. But this understanding of spirituality and spiritual care does not contradict the broader based understandings. It rather concretizes, conceptualizes and enfleshes these understandings.

Feminist theology being praxis oriented can inform practical theology because it values people's experiences including their spiritual experiences. Therefore, language about God is crucial to our experiences of God and to our spirituality because language does not simply reflect but also shapes human experiences with God. Feminist theology can also inform practical theology by recognizing as one of its tasks, the overcoming of old dichotomies and the ushering in of an understanding of pluralism, which gives speech to the speechless and empowers the powerless as well as letting outsiders participate. All people are invited to share in the dialogue of spirituality and healing is a core concern of feminist theology of praxis²⁶². The social transformation envisaged by feminist thought is not seen as just a change in action against the injustices in society but also a personal change in attitude on a level of spirituality, which cannot be legislated.

²⁶² Ackermann and Bons-Storm (1998:7)

I advocate a direction in pastoral care with patients that promotes not only a mere change in action but also a change in attitude at a level that would be called spirituality. The theology which can describe this type of spirituality for people living with HIV and AIDS, is contextual theology. The understanding of God and His relationship with people cannot be captured by fixed and unchanged dogmas and doctrines. It should be rather, explored and anchored in people's lives as expressed in their daily realities²⁶³. I understood the participant's spirituality as the meaning he or she gave to God in life, in the experienced life context of her or his illness. This can only happen if pastoral conversations are not intellectual conversations about God but rather conversations with God. Hence, from a contextual perspective it becomes impossible to do practical theology as though we live in some abstract realm or dead corner of history where others create spiritual realities for others but, we become involved ourselves in our world. It is in this way that we approach pastoral theology as a means of respecting the people living with HIV and AIDS' unique descriptions and experiences of being HIV positive and how God is linked to that experience.

In working with people living with HIV and AIDS, I also want to recommend the social construction perspective in terms of designing pastoral care as follows.

- An individual's spirituality is regarded as being constructed in conversations in the social networks in which the individual finds him/herself. Therefore, it becomes important to attend to the dialogical activity and language that are involved in the shaping of spiritual beliefs. On the other hand social construction allows through language the deconstruction of other spiritual beliefs the patients might have which contribute to the severity of the spiritual problems experienced by the patients. This type of deconstruction assists the patients to deepen their own understandings and knowledges about their experiences and spiritual beliefs. Active incorporation of the patient's spiritual content into the process of therapy can facilitate increased understanding of the patient's experiences and this allows gathering of information regarding the forces which may have helped to create, maintain and perpetuate the presenting problem.

²⁶³ Isherwood and McEvan (1993:9)

- Social construction allows for the reconstruction of the patient's story in therapy using, the constitutive power of language to reposition the patients, as the expert of the discourse within which the patient's subjectivity is inscribed. This allows the pastoral caregiver to be in a not-knowing, uncertainty and reflecting/listening position, which serves to distribute power among all the different voices in the discourse. The pastoral caregiver purposely becomes open, genuine, appreciative, respectful, inviting and curious in a therapeutic relationship that is mutual, collaborative and egalitarian. This will enhance the participatory ethical responsibility of care with patients rather than for patients. This is usually in contrast with the traditional perspective of doing therapy in regards to power relationships between patient and therapist.
- Social constructionist perspective, allows the pastoral caregiver to research for any slight indication of resistance to the dominant problem narrative that can be utilized to create an opportunity for an alternative story. For instance, asking God the why questions in this research was a form of resistance that enabled the participants to develop alternative stories of healing. From a social constructionist perspective, the alternative stories in therapy are chosen from the multiplicity of possible ways of construing a self narrative. Therefore a temporary truth or subjective position may be co-constructed in therapy for that time and this challenges the notion of a person's fixed identity. Subjective is fluid because it is constantly being constituted and reconstructed and sometimes deconstructed by various discourses and being attentive to this battle, the therapist empowers people to choose where they will stand for the meantime. This social constructionist idea of identity being constructed within relationships opens up space for exploring the individual's relationship with God as a way to understand identity constructions and the patient's own experiences of God.

7.7.2.1 Pastoral care

For pastoral care I want to recommend what Pattison (1993:204) describes as gradually turning from the focus on crisis and pathology, to a more holistic approach which moves away from individualized problem centeredness to corporate growth in community. Pastoral therapy is no longer attenuated to crisis pastorate and pathology; instead it is extended to become holistic

when it helps people whose lives are connected with one another to come to richer descriptions of their own situations. This approach to pastoral care, which I recommend is one that does not merely focus on pathology categorizing, diagnosing, characterizing the crisis at the outset, but on the patient's unique context and on care with the patient. Sevenhuijsen (1998:18) elaborates on this by stating that the ethics of care is based on a dual commitment. On one hand, it assumes that people recognize and treat others as different and takes into account other people's individual opinion of the world and of their place within the world. On the other hand, it does not take needs and narratives as absolute truths but interprets them in specific contexts of action. The narratives which people tell of their lives cannot be interpreted as absolute. Instead, they should be interpreted in a specific context of conduct because every person experiences his or her illness as unique in her or his specific context. That is why, categorizing or diagnosing a disease like HIV and AIDS may be an obstacle to spiritual care.

I also recommend that pastoral care should then be spiritual care with people and not care for people. This ethical perspective accentuates the importance of participants in the process of pastoral therapy. Participatory care is committed to the benefit of all. Spiritual care with the patients, regarding them as participants in their own healing process opens the door for social transformation, which is advocated for by contextual and feminist theologies. Social transformation is an important way of taking action in contextual and feminist theologies²⁶⁴. Transformation goes hand in hand with action that leads to change. The verb "doing" expresses an important part of the vocabulary of contextual theology and gets to the heart of theology. Social transformation as a deed of love is aimed at empowering the people living with HIV and AIDS disempowered by society, to believe in their own abilities to become active participants and key role players in the process of transformation.

I want to recommend that in pastoral care, people's conversations with God and their relationship with God has to be respected no matter how nonsensical or mythological they may sound to the pastoral caregiver. The premise here is that, God is far greater than any understanding, experience or writing could ever describe. Therefore, people's experiences with God may differ from the one person to another and from one situation to another. When people

²⁶⁴ Ackermann (1991:108)

talk with another person about their personal relationships with God and conversations with God, a richer meaning is constructed in that conversation. Patients' conversations can be limited if the conversations may become proscriptive, that is God talk is not to be spoken of here but only in other places e.g. worship. God-talk maybe prescriptive, when it is only the therapist's view of God that maybe spoken of and only, in a specific way²⁶⁵. Stories of certainty could also suppress and limit patient's conversations with God in therapy especially when comments like, "I know what God is like for you because I know your religious denomination or I know what God is like to you and you need to know God like me" from the pastoral caregiver are also very limiting. This research has shown that it is important for the pastoral caregiver to move from certainty to curiosity, from centering to wonder, to be willing to be informed by patients about their experiences with God. Hence a narrative approach is recommended as it can serve as a possible tool through which the pastoral caregiver can be better enabled and equipped to work with, support and journey with people living with HIV and AIDS with greater insight, understanding, confidence and effectiveness. Not in the capacity of an expert, but as a companion on the journey who seeks to facilitate change. The recommendations in this regard are made in the next section.

7.7.2.1.1 Narrative therapy with people living with HIV and AIDS

The narrative approach was explored in this study as a possible therapeutic approach, which could be used to journey pastorally with people living with HIV and AIDS. Narrative approach is a non-controlling, non-blaming, non-directive therapeutic approach, that would permit the people living with HIV and AIDS to use their own understanding, thinking, emotions and resources in a way that can bring spiritual healing to their troubled spirits. I therefore recommend narrative therapy in pastoral care for the following reasons.

- As a form of pastoral care, narrative fits very well with the philosophies of contextual, postmodern, participatory and feminist theologies as people living with HIV and AIDS are centralized as experts of their lives and their stories. They are not reduced to being passive recipients of expert professional, theoretical and classification systems be they medical or theologically based. Narrative therapy in this research \was about doing therapy with the participants respectfully, promoting the construction of the patient's life

²⁶⁵ Griffith (1995:123-137).

without enfeebling the patient in the process. It was about learning to avoid ways of speaking and listening that unintentionally express disrespect for others. Narrative therapy centralizes people's own contexts through their story telling in a meaningful way of giving expansion to contextual, feminist and postmodern theologies. Kotze (2002:30) purports, 'the more we participate in such a way that the voices of all especially those who have been previously silenced, can be heard, the more we can research and co-construct in an ethical, just and ecologically sound world to live in.'

- Narrative approaches in practical theology could be described as having a long intrinsic history of their own relationship because in one way or other human stories are connected with narratives from people's spiritual traditions allowing contemporary people to join in with their own life stories. Spiritual care focuses on those individual stories as they connect with spiritual traditions in co-creating new stories of hope.
- Narrative research in practical theology allows marginalized stories and voices to be heard, firmly placing their practical theological endeavor in philosophies of contextual, postmodern, participatory and feminist theologies. Narrative research with the epistemologies of postmodern and social construction as demonstrated in this research has high potential to uncover the process of giving meaning to life experiences through life stories ensuring that the relationship between researcher and participants is constitutive. The ethical consideration, in narrative research, subjectivity is central as the choice of participants defines the kind of results the researcher will get. This makes the researcher aware that research is not an objective analysis of reality but another narrative re-constructed that bolsters or challenges the participants' stories. The researcher becomes a player changing and supporting some participants' narratives over against others.
- Narrative perspective serves as a meta-theoretical framework to help us understand the connection between theology and social science, and the discussion of contesting approaches with both worlds. Because of this meta-theoretical character and the growing body of literature in social science, there is a strong potential for interdisciplinary communication and research. Taking a narrative approach in research in practical

theology involves a hermeneutical stance in which the individual's biography and spiritual construction are valued over general descriptions and statistical averages. And from a practical theological point of view, this is recommended and called for if we want to do justice to the voices of the oppressed, unheard and if we want to acknowledge the spiritual individual. From a social scientific perspective, it is guaranteed, given the reality of a more fragmented and pluralistic society. People construct their own spiritual realities from various religious traditions and worldviews and not others creating for them.

- As a critique, narrative approach runs the risk of becoming too cerebral, verbal and cognitive. This research has tried to work with a broad understanding of narrative. Even then the model itself is more on the level of words and meanings which may give undue preference to verbal knowledge. A connected critique is that narrative approaches show limited attention to power issues and vested interests. Although this maybe the case with naïve interpretations, this research has shown that narrative approach may serve well to highlight power dynamics rather than hide them. The narrative approach brings about a revaluation of human subjectivity. This research seemed to assure that narrative approach is an important perspective in practical theology as it offers a different approach to spiritual realities and a fresh way to analyze and do spiritual care.
- The pastoral caregiver using the narrative approach considers herself to be part of an interactive cycle of negotiating meaning/identity including the meaning made of spiritual matters and ideas even about spirituality. These are not imposed on the patient by the therapists. Only if the patients consider the spiritual dimension as being important in their lives, then talk on spiritual matters will be invited. Therapy becomes more of an art and a way of being than merely following certain procedures or techniques according to a presented set of constructed truths.

7.7.4 Recommendations for the PHC

According to the Zimbabwe National HIV and AIDS policy, health care professionals within the primary health care delivery system are entrusted with the holistic care of people living with HIV and AIDS. This raises the expectation that the nurses and other healthcare providers must care

for the whole person in a way that acknowledges the mind-body-spirit connection. The strong suggestion which has emerged from this study is that spiritual and pastoral care of people living with HIV and AIDS should be incorporated into the primary healthcare delivery system in Zimbabwe because spiritual care is part of the holistic care. Therefore, the following recommendations are made in line with this strong suggestion to the primary healthcare delivery system in Zimbabwe.

- Medical schools in Zimbabwe may offer courses in spirituality as well as develop curricula in spirituality. Lemmer (2005:311) notes; “One of the greatest challenges in dealing with the spiritual dimension of the human person is that the spirit is not a concrete objective reality and if healthcare providers are to attend to the spiritual needs of their patients, they must understand the vast array of cultures and their belief systems.” This research demonstrated how important this is in offering spiritual care to people living with HIV and AIDS. Therefore, the expectation is that healthcare professional must provide a level of spiritual care that meets the guidelines of cultural competence and respects different cultural values and belief systems. The lack of training or confidence in spiritual care giving may be due to several reasons; the most obvious one being that, spiritual care giving is a relative new field of practice in Zimbabwe and Africa in general. Therefore, it is of the utmost importance that the facilitator of such an interactive process is familiar and at ease to be able to share from their personal spiritual experiences. This will create a space for ‘alive moments’ as the essential ingredients of all spiritual care teaching. Being aware of and looking after one’s own spiritual needs is a major contributing factor in feeling confident and gaining competence in being engaged in spiritual care giving. Furthermore, it supports a clearer understanding of boundary issues regarding exactly whose spirituality is being cared for.
- Healthcare professionals must also become confident and competent with spiritual care giving as well as expanding their skills in assessing the spiritual domain. This will assist them to develop and implement appropriate spiritual interventions. Spirituality among the healthcare professionals can be introduced as part of their training programme and to continue as in-service training as they work. This is imperative to bring an awareness

among the health professionals to value their own spirituality and its importance in working within the health settings with sick patients who maybe palliative. The promotion of spirituality among the healthcare workers may positively help them to promote it among the patients they work with and care for. Spiritual care training which includes oneself seems to provide benefits for trainees as well as for their patients.

- Healthcare professionals need to be aware that patients need a trusting and caring relationship with their care provider in order to feel spiritually supported and nurtured. In providing spiritual care and addressing the spiritual needs of patients, healthcare providers face many challenge. Regardless of their belief systems, healthcare professionals must not allow their own biases to prevent them from appreciating the fact that spiritual beliefs play an important role for many of their patients. Respect for the patients' spirituality or religious perspective must transcend the medical care giver's ideology.
- It is possible that the spiritual needs of health care professionals can be neglected. Staff may be uncertain of their own spirituality and challenged in the course of their work with questions of their own mortality. The meaning and purpose of suffering can also be issues they may struggle with in their efforts to provide spiritual care. In some cases this may lead to burnout. Attending to the spiritual needs of staff is important as they bring their whole selves to work with patients. Meeting the spiritual needs of patients may be somewhat perplexing to the /health care staff and may lead to lip service being paid to this aspect of care with only the most obvious of religious needs being addressed. For health care staff, it is good practice therefore to have developed a reasonable understanding of where the patient is psychologically, emotionally and spiritually before the patient enters the terminal phase of their life. Needs change and in keeping with good practice there should be regular reassessment of all needs over time.
- The incorporation of spiritual care into the healthcare setting must involve the consideration of ethics, which focus on medical procedures, patients' rights, business conduct and an array of organizational issues from hiring to severance. Thinking

ethically about new initiatives in the area of spiritual care is therefore essential within the primary health care system in Zimbabwe.

- Other care providers can be called upon as resources for providing spiritual care within the primary health care delivery system such as physicians, nurses, psychologists, HIV and AIDS counselors, social workers, traditional healers, faith healers or prophets. These can be described as spiritual care generalists while clinical pastoral therapists are described as specialists. Those who have not received training in the area of spiritual care and counseling can make referrals to the clinical pastoral therapist. Koeng (2004:1199) strongly argues that the primary role of the physician and nurses is to ask questions and become aware of any spiritual issues that might affect medical care and mobilize the resources necessary to address them. And if spiritual issues are present then the trained specialists, i.e. clinical pastoral therapists need to be brought in, just as a neurologist would be consulted for neurological problems. Handzo (1996:45) reminds us that regardless of the patient's ethic, religious or cultural background, the clinical pastoral therapist can address these issues both in terms of the common human experience and with an informed perspective on and reverence for the specifics of the patient's background. With time, as the health care professionals receive training in this area they will assume a more active role in the spiritual care process. As this research has revealed new relationships and connections, health care practices must be modified to best meet the needs of patients and to provide optimal, quality, integrated healthcare.
- Universities and religious training institutions in Zimbabwe could perhaps offer qualifications for pastoral care in general and clinical pastoral care specifically. At the present moment there is no university in Zimbabwe which is offering clinical pastoral care and in most faculties of theology and religion in the universities, do not have the department of practical theology. Hence the call to offer spiritual care within the primary healthcare delivery system calls these universities and other institutions to think along these lines. It would be of help to consult other universities in Africa like Stellenbosch where Clinical pastoral care is being offered at Masters Level to those with psychology

and theology as their background. The training modules can be modified to fit the context of Zimbabwe.

7.7.5 Recommendations for future research

From the stories of the participants, it is clear that people living with HIV and AIDS experience many problems apart from the spiritual pain. Of interest is what the participants referred to as the chain reaction in the spiritual cause of HIV and AIDS. I observed that all the participants being married, got the HIV infection within their marriages. This seemed to suggest that broken marriages created the gap which allowed the HIV to become the silent partner in their marriages. With this in mind, I want to recommend that more research can be done in terms of Shona marriages within the HIV and AIDS pandemic. Such a research may contribute to the prevention of new HIV infections and re-infections within marriages in Zimbabwe. Such a study may also assist with the caring of married people within the HIV and AIDS pandemic. Most of the prevention and care programmes being offered to HIV and AIDS patients are directed mainly to the individual. Hence such a study may help in this regard.

Another area of my concern as experienced in this research is that of discordant couples. There is very little information on this special population within the HIV and AIDS discourse. I have never come across any care programmes regarding their needs. I recommend that there is need to carry out a study on their care needs as well as giving them a voice to be heard among the many voices of those living with HIV and AIDS.

I also observed in the study that children infected by HIV and AIDS face many challenges especially when they become adolescents. I asked myself how many of these children will disclose their HIV and AIDS status to their girlfriends or boyfriends? How many of them adhere to their medication in terms of them being at school without the fear of being stigmatized by other children? How many parents are comfortable to know that the other child in their child's class is HIV positive? I just wondered what type of care and support services can be designed for these children. Hence more research can be helpful in this matter.

As I interacted with the healthcare professionals at the hospital, I noticed how busy they were. Everyday hundreds of HIV patients come to the hospital for many reasons and just a few nurses

attend to them. I couldn't ignore the tiredness expressed on their faces and sometimes they would talk to the patients in a loud voice. I just wondered whether some of them could be suffering from burnout and if so, do they get any kind of care and support within the hospital system. I recommend that this could be an area which can be researched in future and can give insight to the care and support which can be rendered to health professionals working in such environments.

I recommend that more research is needed to investigate what could be the spiritual issues, concerns and needs of other patients suffering from the so called "incurable diseases" e.g. cancer who are also receiving care within the primary health care delivery system and how can those needs be addressed. An article by Feldstein (2001:1291-1292) provides an insightful closure to the recommendations for future research. Being a physician, Feldstein undertook the care of an 86 year old woman who suffered from brain cancer. Dr Feldstein was to review the current scan and make recommendations as to further medical care. Upon discovering that the cancer had spread, the following conversation took place:

I pulled up a stool next to the gurney and sat down. 'Mrs. Martinez, the CT scan is abnormal.' I said. 'It shows that the cancer has spread to the brain.' Mrs. Martinez looked down. Her face became pale and stricken. I was keenly aware that this was not the kind of test result one simply tells a patient and walks out. Gently, and after a long pause, I asked, 'What is your reaction?' 'This is a death sentence,' she said, looking away. 'What could the doctor do? He noticed a crucifix around the patient's neck. He asked if she would like to pray. 'Yes, I would.' So, the doctor of the body knew that right then what she needed more than anyone was a doctor of the spirit.

Who better then to address the issues of the spirit, than a clinical pastoral caregiver that works alongside medical personal? Vande Creek and Burton (2001:3) summarize the magnitude of the role a clinical pastoral caregiver plays as part of a broader medical team in the lives of hospital patients by saying, "institutions that ignore the spiritual dimension in their mission statement or daily provision of care increase their risk of becoming only biological garages where dysfunctional human parts are repaired or replaced. Such prisons of technical mercy obscure the integrity and scope of persons."

7.8 Conclusion: Collecting my thoughts

The study does not claim to have the solutions or quick fix miracle to the complicated spiritual pain of people living with HIV and AIDS and neither claims to have the power to bring any neat conclusions to the spiritual healing of people living with HIV and AIDS. However, the study has the potential to stimulate a new story of spirituality as a vital resource in the healing process of people living with HIV and AIDS and ignoring it may defeat the purpose of a holistic approach to the care of people living with HIV. Hence, the story of practical theology that emerged from this study is that, which is local and contextual in a way that identifies with people living with HIV and AIDS. It is not a system of theories formulated and then imposed on a certain situation, or people, but a story of seeking deep understanding, which grew from a real situation of living with HIV and AIDS. It is a story developed out of an interaction between researcher, research participants and a context. It finds its identity in a balance and dialogue between theological traditions and their context. It is a practical theology that is sensitive, descriptive but also bold in its deconstruction of negative discourses and in its development of new alternative stories. The strong suggestion emerging from this story is that, spiritual care of people living with HIV and AIDS must of necessity be integrated into the holistic approach to the care of people living with HIV and AIDS in Zimbabwe. The wish of participants that their spiritual well-being be considered in their health care adds momentum to this suggestion. The study also emphasized the position of people living with HIV and AIDS, which they can inhabit and lay claim to the many possibilities of their own lives that lie beyond the expertise of the pastoral caregiver. The re-authoring of alternative stories is an ongoing process and spiritual care never ends. Every ending is a beginning and out of incessant storytelling, new depths and meaning are found. However, as in all journeys, there are landmarks that indicate achievements, places of transfer or starting new directions or turning around. Hence this research/therapeutic process may be regarded as a landmark that indicated a new direction in the participants' journey to spiritual healing.

The strong suggestion which has emerged from this study that, spiritual care must of necessity be integrated into the holistic approach to the care of people living with HIV and AIDS in Zimbabwe, points out that obviously a medical response to the HIV and AIDS pandemic is essential but unfortunately it is not the only vital response. Frank (1995: xi) states that “ the

science of technology may be challenging and fascinating but no longer can we medicalise the situation and forget the person.” Walter and Smith (1988: xi) express the idea that HIV and AIDS is much broader than the often parochial medical interpretation as they state,

The worldwide medical community was slow to recognize the broad spectrum of ways in which AIDS would affect individuals, families and societies. People who have been exposed to the virus are uncertain about their future. Others worry about becoming infected. Family life is disrupted when children, mothers and fathers develop either the clinical illness called AIDS or some related symptoms associated with the virus.

The research has echoed the above sentiments and hopes that, spiritual care will be incorporated into the primary health delivery system in Zimbabwe in the near future, as part of the holistic approach to the care of people living with HIV and AIDS.

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APPENDIX A



UNIVERSITEIT • STELLENBOSCH • UNIVERSITY
jou kennisvennoot • your knowledge partner

4 September 2013

Tel.: 021 - 808-9183
Enquiries: Mrs S. Oberholzer
Email: oberholzer@sun.ac.za

Reference No. DESC 4/2012

Ms F Tamirepi
Faculty of Theology

LETTER OF ETHICS CLEARANCE

With regard to your application, **DESC_4/2012** I would like to inform you that the project "*HIV with the primary health care system in Zimbabwe: The quest for a spiritual & pastoral application to healing*", was approved on the following proviso's:

The researcher will remain within the procedures and protocols indicated in the proposal, particularly in terms of any undertakings made in terms of the confidentiality of the information gathered.

1. The research will again be submitted for ethical clearance if there is any substantial departure from the existing proposal.
2. The researcher will remain within the parameters of any applicable national legislation, institutional guidelines and scientific standards relevant to the specific field of research.
3. The researcher will consider and implement the foregoing suggestions to lower the ethical risk associated with the research.
4. This ethics clearance is valid for one year from **26 April 2012 – 25 April 2013**

We wish you success with your research activities.

Best regards


.....
MRS S. OBERHOLZER

REC Coordinator: Research Ethics Committee: Human Research (Humaniora)

Registered with the National Health Research Ethics Council (NHREC): REC-050411-032



APPENDIX B



UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
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STELLENBOSCHUNIVERSITY REQUEST FOR CONDUCTING RESEARCH

Department of Practical Theology

& Missiology

Faculty of Theology

171 Dorp Street

7600 Stellenbosch

South Africa

2 February 2012

The Director

The Provincial Medical Director

Midlands Province

Gweru

Zimbabwe

Request to conduct a research study:

Farirai Tamirepi is currently studying for a PhD in Practical Theology at Stellenbosch University, South Africa. She is expected to conduct a research study as a requirement for the degree. The research study has an empirical dimension and may I therefore request for permission for her to conduct this study at Gweru Provincial Hospital.

The topic for Ms Tamirepi's research is: **HIV and AIDS within the primary health care delivery system in Zimbabwe: A quest for a spiritual and pastoral approach to healing.**

This is a qualitative Practical Theological research study and it involves the use of narratives of people living with HIV and AIDS in order to study and understand their spiritual problems and needs from their perspectives. The participants in the study are people living with HIV and AIDS who are receiving care at the Gweru Provincial Hospital. The research will run for the duration of three months starting in March 2012. Individual and group sessions will be conducted twice a week respectively and each session will be for about two hours. Participants will be asked to voluntarily participate and will be allowed to withdraw their participation for whatever reason at any time. The research will be conducted in absolute confidentiality and the anonymity of the participants will be protected at all stages of the research as well as in the reports on the final findings. Should you have any questions regarding the participants' rights as research subjects, you may contact myself or contact Ms Maléne Fouché (mfouche@sun.ac.za; +27 21 808 4622) at the Division for Research Development.

Your cooperation in this regard will be highly appreciated.

Yours faithfully

.....

Prof. J.H. Cilliers (Head of Department)

Tel: +27 21 808 3864

Fax: +27 21 808 3251

e-mail: jcilliers@sun.ac.za

APPENDIX C



UNIVERSITEIT•STELLENBOSCH•UNIVERSITY
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STELLENBOSCH UNIVERSITY CONSENT TO PARTICIPATE IN RESEARCH

RESEARCH TITLE: HIV and AIDS within the primary health care delivery system in Zimbabwe: The quest for a spiritual and pastoral approach to healing

Principal Researcher: Farirai Tamirepi (PHD candidate)

You are asked to take part in a research study conducted by **Farirai Tamirepi** from the department of Practical Theology at Stellenbosch University. You were selected as a possible participant in this study because you are receiving HIV care and counselling from Gweru Provincial Hospital. Should you decide to participate I will be most thankful. Should you decide not to take part there will be no disadvantages to you or anyone.

PURPOSE OF THE STUDY

The purpose of this study is to explore the existence of spiritual needs of people living with HIV and AIDS and co-create a spiritual and pastoral approach to healing with people living with HIV and AIDS which is contextual and relevant to the Zimbabwean context as part of the holistic approach to care and counselling of people living with HIV and AIDS within the primary health delivery system.

PROCEDURES

If you volunteer to participate in this study you will be asked to give consent for the information obtained during the individual and group sessions to be used in the research report.

Should you decide to take part in this study you will be expected to attend two individual and two group sessions of about two hours each per week for three months. After each session you will receive a summary of the session. You will be asked to make comments, corrections and/or provide feedback regarding the summary.

Although the sessions will be in Shona, the research report will be in English. Therefore all the summaries as well as other correspondence will be in English. At your request those can be translated into Shona.

No financial reward or any form of payment will be made for taking part in this study. You are free to withdraw from the research project at anytime without any consequences to you.

CONFIDENTIALITY

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. The information will be discussed with my supervisor and will be used in the project. With your prior consent the sessions will be audio taped. However if you wish that I make notes, I will be happy to do that. I will provide you with a summary of the sessions. Your comments, corrections and feedback will be included in the final report.

You are assured that the information collected during the project will be securely stored in a locked filing cabinet and will be destroyed after concluding the project. Only my supervisor and I will have access to the audiotapes and notes taken during the sessions.

Results of this project may be published. At your request details, names and places will be distorted to ensure anonymity. You will have the choice to use your own name or pseudonym of your own choice. A copy of the report will be made available to each participant.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The researcher may withdraw you from this research if circumstances arise which warrant doing so.

Identification of Researcher

If you have any questions or concerns about the research now or in the future, please feel free to contact me:

Farirai Tamirepi

Mobile: +263778019403 or +27786537692

Email: fariraitams@yahoo.co.uk

Or my supervisor

Dr.Christo Thesnaar

University of Stellenbosch

Department of Practical Theology (Pastoral Care)

Mobile: +27845734322

Email: cht@sun.ac.za

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research participant, you may contact the **Medical Research Council of Zimbabwe on telephone 04 791792 or 04 791193.**

OFFER TO ANSWER QUESTIONS

Before you sign this form, please ask any questions on any aspect of this study that is unclear to you. You may take as much time as necessary to think it over.

AUTHORIZATION

You are making a decision whether or not to participate in this study. Your signature indicates that you have read and understood the information provided above, have had all your questions answered, and have decided to participate.

The date you sign this document to enroll in this study, that is, today's date, **MUST** fall between the dates indicated on the approval stamp affixed to each page. These dates indicate that this form is valid when you enroll in the study but do not reflect how long you may participate in the study. Each page of this Informed Consent Form is stamped to indicate the form's validity as approved by the Medical Research Council of Zimbabwe.

Name of Research Participant (please print)

Date

Signature of Witness

Signature of researcher

Optional

YOU WILL BE GIVEN A COPY OF THIS CONSENT FORM TO KEEP.

APPENDIX D

Telephone: 221394/7
Telegraphic Address
Govt. Complex 10th Street
Fax: 224724



MINISTRY OF HEALTH &

CHILD WELFARE
PMD MIDLANDS
P O BOX 206
GWERU

19 MARCH 2012

Medical Research council of Zimbabwe
HARARE

RE: HIV AND AIDS WITHIN THE PRIMARY HEALTH CARE DELIVERY
SYSTEM IN ZIMBABWE: THE QUEST FOR A SPIRITUAL AND PASTORAL
APPROACH TO HEALING: RESEACHER MS. FARIRAI TAMIREPI TRANEE
PHD THEOLOGY UNIVERSITY OF STELLENBOUSCH.

The PMD Midlands province, Dr. Milton Chemhuru has read through the study proposal mentioned above, author Ms. Farirai.
The PMD is satisfied that the study is relevant to our HIV and AIDS situation in the province. I am confident that the findings of this study will benefit both the people living with HIV, the implementers and as well as the policy makers.

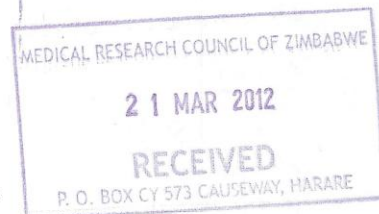
Above all the MoHCW has the policy of partnership in both research and HIV and AIDS activities with the communities and partners.
This is the first such a study (I believe) in this province.

I there give permission through the Medical Research Council, for the study to be carried at Gweru provincial Hospital.

The Hospital medical superintendent is also given the study proposal for his own information.

DR. M. Chemhuru
(PMD midlands province.

Cc. Medical superintendent Gweru provincial Hospital).



APPENDIX E

Telephone: (263) - 4 - 791792/791193
Telefax: (263) - 4 - 790715
E-mail: mrc.zimbabwe@yahoo.com
Website: <http://www.mrcz.org.zw>



Medical Research Council of Zimbabwe
Josiah Tongogara / Mazoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL LETTER

Ref: MRCZ/A/1662

05 June 2012

Farirai Tamirepi
30 Gordon Crescent
Athlone
Gweru

RE: HIV AND AIDS WITHIN THE PRIMARY HEALTH CARE DELIVERY SYSTEM IN ZIMBABWE. A QUEST FOR A SPIRITUAL AND PASTORAL CARE APPROACH TO HEALING.

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review:

- a) Completed MRCZ Application form
- b) Protocol Summary,
- c) Full Protocol, Version
- d) English and Shona versions of the Informed Consent Forms

• **APPROVAL NUMBER** : MRCZ/A/1662

This number should be used on all correspondence, consent forms and documents as appropriate.

- (i) MRCZ MEETING DATE : 26 April 2012
- (ii) EFFECTIVE APPROVAL DATE : 05 June 2012
- (iii) EXPIRATION DATE : 04 June 2013
- (iv) TYPE OF MEETING : Full Board

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ Offices or website should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ Offices.
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ Offices.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrc.zimbabwe@yahoo.com

Other

- Please be reminded to send in copies of your research results for our records as well as for Health Research Database.
- You're also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully

MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



Membership Certificate



We are all one and love unites us

THIS IS TO CERTIFY THAT IS A MEMBER OF

GWERU RUDO CHETE SUPPORT GROUP

PRESENTED AT GWERU PROVINCIAL HOSPITAL

Date



Signature

APPENDIX F



Certificate of Acknowledgement

This is to certify that has knowledges and understanding of experiences of spiritual pain, the ways the spiritual pain operates in people's lives, the spiritual needs and the quest for healing of people living with HIV and AIDS. These knowledges and understanding acquired have the potential to assist and support people living with HIV and AIDS who are questing for spiritual healing.

Signed by _____

Witness 1 _____

Witness 2 _____

This good news is to be shared with

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APPENDIX G